

THE UNIVERSITY OF FINDLAY

EMPLOYEE CONFIDENTIALITY AGREEMENT

I, _____, have read and understand the policies of The University of Findlay (UF) regarding the privacy of protected health information (PHI) as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, I acknowledge that I have been instructed in UF's policies regarding the use, disclosure, storage and destruction of PHI as required by HIPAA.

In consideration of my employment with UF I hereby agree that I will not at any time, either during my employment with UF or after my employment ends, use, access or disclose PHI to any person or entity, internally or externally, except as required or permitted in the course of my duties and responsibilities with UF, as described in UF's privacy policies and procedures or as permitted under HIPAA. I understand that this obligation extends to any PHI that I may acquire during the course of my employment with UF, whether in oral, written or electronic form and regardless of the manner in which access to PHI was obtained.

I understand that the unauthorized use or disclosure of PHI can result in disciplinary action, up to and including termination of employment with UF, and the possible imposition of civil penalties and criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment with UF, regardless of the reason for such termination.

Signed _____ Date _____