



REGISTRY PROVIDER ACKNOWLEDGEMENT

HIPAA TRAINING AND CONFIDENTIALITY AGREEMENT

VENDOR NAME:

REGISTRY PROVIDER:

I fully understand the federal regulations regarding the HIPAA Privacy Rule.

I also agree as follows:

1. To consider all Client information private and confidential for use by only those involved in billing and Client healthcare operations;
2. To access only information I have been instructed to or authorized to access in order to perform my job;
3. To protect the confidentiality of all Client and patient protected health information;
4. To not misuse, share, alter or destroy any confidential information unless it is required to perform my job;
5. To report any breach of confidentiality to the Client;
6. To face disciplinary action up to and including termination if I fail to comply with this agreement.

Printed Name

Signature

Date Signed