

EMPLOYEE PRIVACY AGREEMENT

NAME OF EMPLOYER/PLAN SPONSOR:

NAME OF PLAN:

EFFECTIVE DATE:

As an employee, of the above Plan Sponsor working in support of the above Plan, I understand that I may have access to confidential information concerning the protected health information (PHI) of Plan Participants or other employees. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires protection of protected health information and inappropriate disclosure of PHI may result in the imposition of fines up to \$250,000 and ten years imprisonment per incident.

Accordingly, as a condition of and in consideration of my access to PHI, I acknowledge that I have received training on the uses and disclosure of PHI and that I will abide by the rules governing the protection of Protected Health Information including:

1. I will not access confidential information for which I have no legitimate need to know and for which I am not an authorized user.
2. I will not divulge, copy, use, disclosure, release, sell, loan, review, change or destroy any PHI unless the Privacy Officer named by the Plan Sponsor authorizes such action.
3. I will not utilize another user's password in order to access any system nor will I reveal my computer credentials to anyone else for any reason. I accept personal responsibility and understand that I will be held accountable for all activities occurring under computer credentials.
4. If I observe or have knowledge of unauthorized access or divulgence of confidential information I will report it immediately to my supervisor or the Privacy Officer.
5. I will not seek personal benefit or permit others to benefit personally by any confidential information that I may have or that I access as an unauthorized user.
6. I understand that all information, regardless of the media on which its stored (paper, computer, videos, recorders, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.), or the methods by which its moved (electronic mail, face to face conversation, facsimiles, etc.) is the property of the plan Sponsor and shall not be used inappropriately or for personal gain. I also understand that the Plan Sponsor reserves the right to inspect or monitor any company owned, leased, or controlled computer, computer device, network, computer facility, storage device, voice mail or telephone system at any time for any reason and that the Plan Sponsor may divulge any information found during such inspections or monitoring to any party it deems appropriate. I understand that I should not consider electronic communications to be either private or secure, nor have an expectation of privacy in anything I create, store, send, or receive on the computer and network.

7. I agree to abide by all of the rules and regulations specific in the procedures published by the Plan Sponsor.

8. I understand that my failure to comply with this Agreement may result in corrective action, which might include, but is not limited to, termination of employment and/or loss of my privileges, as well as potential civil or criminal penalties.

By signing this agreement, I acknowledge that the Plan Sponsor has an active on-going program to review records and transactions for inappropriate access and I understand that inappropriate access or disclosure of information can result in penalties up to and including termination of employment and/or legal action.

Signature: _____

Date: _____

Print Full Name: _____

Employee #: _____