CONFIDENTIALITY AGREEMENT

As an employee, student or volunteer of Northwoods Therapy (hereinafter "Provider"), and as a condition of my employment, I agree to the following:

1. I understand that Provider is required under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") to protect the confidentiality of individually identifiable health information created or received by Provider in providing services to patients ("Patient Information") and to safeguard the privacy and security of Patient Information.
2. I understand that I am responsible for complying with HIPAA and the Privacy Policies, which have been provided to me in written form.
3. I will treat all Patient Information received in the course of my employment with the Provider as confidential and privileged information.
4. I will not access Patient Information unless I have a need to know this information in order to perform my job functions. If I have any question about whether certain information is required for me to do my job, I will ask my supervisor or the Privacy Officer for clarification before accessing the information.
5. I will not disclose Patient Information to any person or entity, other than as necessary to perform my job functions and as permitted by HIPAA and the Privacy Policies.
6. I will not log on to any of the Provider's computer systems that currently exist or may exist in the future using a password other than my own.
7. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my nametag.
8. I will not allow anyone, including other employees, to use my password to log on to the computer.
9. I will log off of the computer as soon as I have finished using it.
10. I will not use e-mail to transmit Patient Information unless I am authorized to do so by the Privacy Officer, and only if such transmission of information is required for the performance of my job.
11. I will not take Patient Information from the premises in paper or electronic form without first receiving permission from the Privacy Officer. If I am authorized to do so, I agree to keep any records containing Patient Information that I take off the premises secure and to abide by Provider's policies regarding the confidential and secure treatment of Patient Information with respect to such records. For example, I will not leave Patient Information unattended.
12. I will notify the Privacy Officer immediately of my discovery of any of the following: any use or disclosure of Patient Information not permitted by the Privacy Policies; any attempted or successful unauthorized access, use, disclosure, modification or destruction of Patient Information; and any other potential breach of security or failure to comply with the Privacy Policies. I will cooperate with the Provider in every way to help regain possession of its Patient Information and prevent further unauthorized use or disclosure.
13. Upon cessation of my employment, I agree to continue to maintain the confidentiality of any Patient Information to which I had access while an employee and agree to turn over any keys, access cards, or any other device that would provide access to the facility or its information.
14. I agree that my obligations under this Agreement regarding Patient Information will continue after the termination of my employment with Provider for any reason.

I understand that violation of this agreement could result in disciplinary action, up to and including termination.

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Name (print) Date

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Name (signature)