FSC INDIVIDIAL EMPLOYEE HIPAA NON-DISCLOSURE/CONFIDENTALITY AGREEMENT

I have read and understand Family Service Center of Galveston County (FSC) policies regarding the privacy of individually identifiable health information (or protected health information ("PHI")), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In addition, I acknowledge that I have read and understand FSC policies regarding protection, disclosure, and disposal of client information. I further understand that, through my affiliation with FSC, I will be exposed to privileged, intimate, and personal information in addition to PHI (such information and PHI shall collectively be referred to as "PHI" herein). I understand that HIPAA requires FSC to have detailed policies and procedures in place that dictate how employees can use client information, when they can disclose it, and how they should dispose of it. In consideration of my employment with and/or compensation from FSC, I hereby agree that I will not at any time—either during or after my employment or affiliation with (a) FSC or (b) its clients—use, access or disclose PHI in any manner to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with FSC or its clients, and as permitted under the FSC privacy policies and procedures as adopted and amended from time to time, or as permitted under HIPAA. I understand that this prohibition includes, but is not limited to, disclosing any information about the identity of the clients with whom I work or any information about them, including their medical and other personal information, to family, friends, other clients, other clients, or co-workers, unless such person is lawfully authorized to receive such information.

I agree to document uses and disclosure of PHI as required by the clients and/or HIPAA, and to return or destroy all PHI associated with the clients upon the termination of my services as directed. I agree that I immediately will report to FSC and to the client with which I am placed any impermissible PHI use or disclosure. I understand that my personal access codes, user IDs, access keys, passwords, and similar access information will be kept confidential at all times. I understand that I will not remove from FSC any devices or media unless authorized to do so, and I agree to use such devices or media only as authorized. I agree to access only such client information as necessary in the pursuit of my authorized duties. I agree to enter into the medical record only that information which is legible, timely, and which documents and reflects the clients past or present medical status and treatment. I agree to return all means of access to PHI immediately upon termination of my employment with FSC. I understand and acknowledge my responsibility to apply the policies and procedures of FSC. I understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of employment or affiliation with FSC and its clients and could result in the imposition of civil and criminal penalties under applicable laws, as well as professional disciplinary action. I understand that my obligations will survive the termination of my employment or end of my affiliation with FSC and its clients, regardless of the reason for such termination. I understand that my obligations extend to any PHI that I may acquire during the course of my employment or affiliation with FSC or its clients, whether in oral, written or electronic form and regardless of the manner in which access was obtained. I understand that I should contact an administrative officer of FSC if I have any questions, comments, or concerns about my obligations under this agreement.

I understand that this document with (respect to the subject matter) supersedes any previous documents or agreements.

Signature of Employee: _____ Date: _____

Print Your Name: _____