Confidentiality Agreement

The Health Insurance Portability and Accountability Act (HIPAA) and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient. These medical privacy laws and regulations apply to all members of the University of California, Santa Barbara, Health System (UCSB HS) workforce including faculty, staff, residents, fellows, medical and other health sciences students and volunteers. All members of the workforce of the Health System are required to agree to and sign this confidentiality statement.

CONFIDENTIALITY STATEMENT

As a member of the UCSB HS workforce, I understand that I may be working with confidential medical and other sensitive or private information. This information may include, but is not limited to, medical records, personnel information, ledgers, verbal discussions, and electronic communications including e-mail.

I understand and acknowledge that HIPAA requires that I be trained on the requirements of HIPAA and the UCSB HS policies, procedures and guidelines relating to protection of confidential patient information, and I agree to obtain all required training before I access, use or disclose any confidential patient information.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of patient and other confidential information. I will not access, use or disclose patient or other confidential information unless I do so in the course and scope of fulfilling my duties as a member of the UCSB HS workforce. I understand that I am required to immediately report any information about unauthorized access, use or disclosure of confidential patient information. Initial reports go to the UCSB HIPAA Compliance Officer. If electronic media is involved, an incident report will be forwarded to the Campus Sensitive Data Incident Coordinator.

I understand and acknowledge that, should I breach any provision of this agreement, I may be subject to civil or criminal liability and/or disciplinary action consistent with applicable University policies, bargaining contracts and University processes.

For more information on UCSB HS HIPAA-related policies, procedures and guidelines please contact your departmental HIPAA representative.

Signature	Printed Name	Date