Medical Practice Confidentiality Agreement for Patient Records

This Confidentiality Agreement ("Agreement") is entered into by and between:

Medical Practice: _____
Employee/Contractor: _____

In consideration of employment, engagement, or association with the Medical Practice, the undersigned agrees as follows:

1. Confidentiality of Patient Records

I acknowledge that I may have access to patient records and private information in the course of my duties with the Medical Practice. I understand that such information is confidential and protected by law, including but not limited to HIPAA regulations.

2. Non-Disclosure

I agree that I will not, either during or after my association with the Medical Practice, disclose, copy, release, or remove any patient information except as required in the course of my duties and as permitted by applicable law.

3. Safeguarding Records

I will take all necessary precautions to protect the security and confidentiality of patient records in any form (written, electronic, or oral).

4. Legal Compliance

I understand that unauthorized disclosure of patient information is prohibited and may result in disciplinary action, termination of employment or contract, civil liability, and/or criminal penalties.

5. Return of Information

Upon termination of my employment or association with the Medical Practice, I will return or destroy any confidential patient information in my possession.

6. Acknowledgment

I have read and understand this Confidentiality Agreement and agree to be bound by its terms.

Employee/Contractor Name:

_____
Signature:

_____
Date: _____

Medical Practice Representative Name:

Signature:

Date: