HIPAA-PHI Protection Agreement

- I plan to utilize electronic documentation of patient/client care.
- I will ensure confidentiality and security of patient/client information by password protecting the device or program utilized.
- I agree to change the password at least quarterly or following a breach of security.
- I will not provide my password to anyone.
- I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the Agency.
- I have been informed of the Agency's Medical Record Information Confidentiality Policy and Safeguarding Medical Record Content Policy, and I agree to abide by these policies.
- I have completed the required training on the Texas Medical Records Privacy Act-Texas Health and Safety Code Chapter 181, Section 181.001 (HB300) concerning protected health information as necessary and appropriate to carry out my duties for the Agency.

_____

Printed Name

_____ _____

Signature Date