

Workforce Confidentiality Agreement

I understand that AHR Pharmacy Solutions, hereinafter referred to as AHR, has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information.

In addition, I understand that during the course of my employment/assignment/affiliation at AHR, I may see or hear other Confidential Information such as financial data and operational information pertaining to the practice that AHR is obligated to maintain as confidential.

As a condition of my employment/assignment/affiliation with AHR, I understand that I must sign and comply with this agreement.

By signing this document I understand and agree that:

I will disclose Patient Information and/or Confidential Information only if such disclosure complies with AHR policies, and is required for the performance of my job.

My personal access code(s), user ID(s), access key(s), and password(s) used to access computer systems or other equipment are to be kept confidential at all times.

I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required to do my job, I will immediately ask my supervisor for clarification.

I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any Practice Information in public areas even if specifics such as a patient's name are not used.

I will not make inquiries about any practice information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, modifications, or purging of Patient Information or Confidential Information. Such unauthorized transmission include, but are not limited to, removing and/or transferring Patient Information or Confidential Information from AHR's computer system to unauthorized locations (for instance, home).

Upon termination of my employment/assignment/affiliation with AHR, I will immediately return all property (e.g. keys, documents, ID badges, etc) to AHR.

I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my employment/assignment/affiliation with AHR.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation with AHR and/or suspension, restriction or loss of privileges, in accordance with AHR's policies, as well as potential personal civil and criminal legal penalties.

I understand that any Confidential Information or Patient Information that I access or view at AHR does not belong to me.

AHR and I acknowledge that this Agreement does not obligate AHR to employ me for any particular length of time nor does it obligate me to work for AHR for any particular length of time.

Further, if I should breach this agreement, AHR is entitled to any and all available legal and equitable relief, including injunctive relief, and that I shall be liable for all attorneys' fees, court costs incurred by AHR in the event that AHR is the prevailing party in an action brought to enforce this Agreement.

AHR Pharmacy Solutions
HIPAA/Confidentiality Accountability Form

PRINT THIS FORM, COMPLETE IT, AND FAX TO AHR CORPORATE
OFFICES AT (949) 457-7605

Name

(print)

Social Security Number _____

I have read and understood the AHR Pharmacy Solutions information on Health Insurance Portability and Accountability Act (HIPAA) and the Workforce Confidentiality Agreement. I agree to comply with all the terms of these documents as a condition of my employment.

Signature _____ Date _____