EMPLOYEE CONFIDENTIALITY AGREEMENT
THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
(SBBC)

I, ____ ,
(***please print name***)
have viewed the Health Insurance Portability and Accountability Act (HIPAA) video or received training on privacy regulations from the District's Privacy Officer. I hereby agree to the following terms:

- I will only access, use, disclose, store, or destroy Protected Health Information (PHI) pertaining to students or employees as permitted by HIPAA and in accordance with my duties as a School Board employee.

- I agree to safeguard all individually identifiable health information I access in the course of my employment, and to keep it confidential as required by law and in accordance with School Board Policy #4019 on Protected Health Information.

- I understand privacy protections apply to all forms of PHI, whether oral, written or electronic, and regardless of the manner in which access was obtained.

- I understand unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of my employment or association with SBBC, and the imposition of civil and/or criminal penalties under applicable federal and state law.

- I understand this obligation will survive the termination of my employment or end of my association with SBBC, regardless of the reason for such termination.

Signature: ______________________________________ Date: ______________

School or Departments ____

Position______________________________ Personnel Number _____________

Revised 02-09