Access Family Care, LLC
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Privacy Policies and Confidentiality Agreement

Access Family Care, LLC (AFC) and federal regulations protect the privacy of our patients' health information. The Health Insurance Portability and Accountability Act (HIPAA) is a set of federal rules that defines what information is protected, sets limits on how that information may be used or shared, and provides patients with certain rights regarding their information.

These rules protect information that is collected or maintained, (verbally, in paper, or electronic format) that can be linked back to an individual patient and is related to his or her health, the provision of health care services, or the payment for health care services. This includes, but is not limited to, clinical information, billing and financial information, and demographic/scheduling information. Even the fact that an individual has received care at AFC is protected by our AFC policy and federal regulations.

AFC policy and HIPAA regulations limit the use or sharing of protected patient information to the following purposes: providing treatment, obtaining payment for services, certain health care administrative functions and when required or permitted by law. Any other use or disclosure of protected information requires written authorization from the patient. For all uses or disclosures other than treatment, only the minimum amount of information necessary will be shared on a need to basis.

You are required to conduct yourself in strict conformance to all applicable laws and AFC policies governing confidential information. You may see or hear information related to AFC patients (such as charts and other paper and electronic records, demographic information, conversations, dates, names of physicians, patient financial information, etc.). **Any patient information you see or hear, even incidentally, must be kept confidential. By signing below, you are agreeing to abide by our policies regarding confidentiality of patient health information.**

As a condition of and in consideration of, my use, access, and/or disclosure of confidential information, I,

_____, understand and agree to the following:

- I will access, use, and disclose confidential information only as permitted by AFC. This means that I will only access, use, and disclose confidential information that I have been given authorization to access, use, and disclose.

- I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions will result in the termination of my privilege to observe and participate in clinical areas and I may be subject to legal liability as well.

- My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature: _____ Date: _____