Abide Health Medical APC

6847 W. Charleston Blvd. Suite B
Las Vegas, NV 89117
Phone #: (725) 205-1578 Fax #: (725) 485-3749

Confidentiality Agreement

This **Confidentiality Agreement** ("Agreement") is entered into between **Abide Health Medical APC** (the "Clinic"), and the undersigned employee, contractor, volunteer, or other individual (the "Recipient"), who will be responsible for maintaining the confidentiality of all **Protected Health Information** (PHI) and other sensitive information related to patients of the Clinic.

By signing this Agreement, the Recipient acknowledges and agrees to the following terms and conditions regarding confidentiality and privacy of patient information.

Definition of Protected Health Information (PHI)

For the purposes of this Agreement, **Protected Health Information** (PHI) refers to any health information, whether oral or recorded in any form or medium, that:

- Is created or received by the Clinic or any healthcare provider,
- Relates to the past, present, or future physical or mental health condition of a patient,
- Identifies or could be used to identify a patient, and
- Is protected under **HIPAA (Health Insurance Portability and Accountability Act)**, **Nevada law (NRS 433)**, and other applicable privacy laws.

This includes, but is not limited to:

- Medical records,
- Psychological or psychiatric assessments,
- Treatment plans,
- Medication information,
- Demographic details,
- Billing and payment information, and
- Any other health-related information that is confidential.

Confidentiality Obligations

The Recipient agrees to:

- **Maintain confidentiality**: The Recipient will keep all PHI strictly confidential and will not disclose, share, or discuss any PHI with any unauthorized individuals or parties, except as permitted by law or as necessary for the performance of duties.
- **Restrict access to PHI**: The Recipient will not access, review, or use PHI unless necessary for the performance of their job duties.
- **Comply with legal obligations**: The Recipient will comply with all relevant privacy and confidentiality laws, including **HIPAA**, **Nevada Revised Statutes (NRS 433)**, and any other state or federal laws that protect the confidentiality of health information.

Use and Disclosure of PHI

The Recipient acknowledges that they may be authorized to use or disclose PHI for the following purposes:

- **Treatment**: To provide patient care, counseling, or psychiatric services.
- **Payment**: For billing, payment processing, or reimbursement purposes.
- **Healthcare Operations**: For activities such as quality assurance, administrative support, training, or audits.

The Recipient agrees to **only disclose PHI** to individuals or entities authorized to receive such information, in compliance with applicable law, and only when required for purposes related to patient care, billing, or healthcare operations.

The Recipient further acknowledges that unauthorized disclosure of PHI may result in civil and criminal penalties, as prescribed under **HIPAA**, **Nevada law**, and other applicable laws.

Limits to Confidentiality

While maintaining confidentiality is a key responsibility, the Recipient understands that there are certain circumstances in which the Clinic is required by law to disclose PHI without patient consent. These circumstances may include:

- **Duty to Warn**: If the patient poses a danger to themselves or others, the Clinic may be required to disclose PHI to appropriate individuals, law enforcement, or emergency responders.
- **Child or Elder Abuse**: The Clinic is required to report suspected child or elder abuse to the appropriate authorities.
- **Court Orders**: PHI may be disclosed pursuant to a court order or subpoena.
- **Public Health Reporting**: The Clinic may be required to report certain diseases or conditions to public health authorities as required by law.
- **Telehealth and Remote Access**: If PHI is transmitted or accessed via telehealth services or electronic means, the Recipient agrees to follow the Clinic's protocols to ensure the confidentiality of PHI during transmission, storage, and access.

Safeguarding Confidential Information

The Recipient agrees to take all reasonable precautions to safeguard PHI, including but not limited to:

- **Secure Storage**: All physical records containing PHI will be securely stored, and electronic records will be protected by passwords, encryption, and other security measures.
- **Limited Access**: Only those individuals with a legitimate need to know and who are authorized will have access to PHI.
- **Training**: The Recipient will complete any mandatory training provided by the Clinic regarding the handling of PHI and confidentiality practices.

Breach of Confidentiality

The Recipient understands that any breach of confidentiality, whether intentional or accidental, is a serious violation of Clinic policy and applicable laws. Breaches may include:

- Unauthorized access to or disclosure of PHI,
- Improper use of PHI for personal gain or purposes unrelated to patient care,
- Failure to properly safeguard or secure PHI.

The Recipient agrees to immediately report any suspected breach of confidentiality to the Clinic's **Privacy Officer** or designated representative.

Any violation of this Agreement may result in disciplinary action, including termination of employment or contractual relationship, as well as potential civil or criminal penalties under **HIPAA** or **Nevada state law**.

Return of Confidential Information

Upon the termination of the Recipient's relationship with the Clinic (whether employment, contract, or other), the Recipient agrees to return or destroy any confidential information, including physical and electronic records, that may contain PHI.

Acknowledgment and Agreement

By signing below, the Recipient acknowledges that they have read, understood, and agree to comply with the terms of this Confidentiality Agreement. The Recipient understands that maintaining the confidentiality of PHI is a legal and ethical obligation and that failure to comply with the terms of this Agreement may result in serious consequences.

Patient Name (Printed): _____

Patient Signature: _____ Date: ___ / ___ / _____