DENTAL PRACTICE EMPLOYEE HIPAA PRIVACY, CONFIDENTIALITY, AND SOCIAL MEDIA AGREEMENT

Practice Name: _____

Employee Name: _____

Position: _____

Date of Hire: _____

HIPAA Privacy, Confidentiality, and Professional Conduct Agreement

As a condition of my employment with the above-named dental practice ("Practice"), I understand that I may have access to confidential information, including Protected Health Information (PHI), patient records, financial information, employee information, and other sensitive business information. I recognize my responsibility to protect such information and to comply with all applicable laws, regulations, and Practice policies.

I acknowledge and agree to the following:

1. Confidentiality Obligation

- I will maintain the confidentiality of all patient, employee, and Practice information entrusted to me.
- I will not access, use, discuss, disclose, copy, photograph, transmit, or remove confidential information except as necessary to perform my assigned job duties and as authorized by the Practice.
- I will exercise appropriate care to prevent unauthorized access to confidential information by any person.

2. HIPAA Compliance

- I will comply with all applicable federal and state privacy and security laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.
- I understand that patient information may only be accessed on a legitimate need-to-know basis for treatment, payment, healthcare operations, or other authorized purposes.

- I will only access patient information necessary to perform my job duties and will not access records out of curiosity or for personal reasons.

3. Protection of Information

- I will safeguard passwords, access credentials, records, electronic devices, and all other means used to access confidential information.
- I will not share passwords or allow unauthorized individuals to use my login credentials.
- I will secure confidential information from unauthorized viewing, use, disclosure, alteration, or destruction.
- I will immediately report any suspected privacy, security, or confidentiality violation, including lost devices, unauthorized access, or inappropriate disclosures.

4. Restrictions on Disclosure

- I will not share patient information with family members, friends, coworkers without a legitimate need to know, vendors, or any unauthorized individual.
- I understand that discussing patient information in hallways, elevators, waiting rooms, restaurants, public places, or other areas where information may be overheard is prohibited.
- I will not disclose confidential information unless authorized by the Practice and permitted by applicable law.

5. Continuing Obligation

- My obligation to protect confidential information continues throughout my employment and after my employment ends.
- Upon termination of employment or upon request, I will immediately return all Practice property, records, documents, devices, and confidential information in my possession.
- I will not retain copies of any Practice or patient information following the end of my employment.

6. Acknowledgment of Consequences

- I understand that violations of HIPAA, Practice policies, or this Agreement may result in disciplinary action, up to and including termination of employment.

- I understand that violations may also subject me to civil penalties, criminal penalties, professional disciplinary action, and other legal consequences under applicable law.

7. Social Media and Electronic Communications

- I understand that patient privacy extends to all forms of communication, including social media, text messages, email, blogs, websites, messaging applications, and online forums.
- I will not post, share, upload, transmit, or discuss any patient information, photographs, radiographs, videos, treatment details, appointments, or other identifiable information on social media or any electronic platform unless expressly authorized and permitted by law and Practice policy.
- I will not take photographs, screenshots, videos, or recordings of patients, patient records, computer screens, schedules, or Practice information using personal devices unless expressly authorized for legitimate business purposes.
- I understand that even when a patient's name is omitted, information may still identify the patient and constitute a HIPAA violation.
- I will not represent myself as speaking on behalf of the Practice unless specifically authorized to do so.
- I will maintain professional conduct online and will not disclose confidential Practice information, business information, employee information, financial information, or proprietary information obtained through my employment.
- I understand that violations of this Social Media and Electronic Communications provision may result in disciplinary action up to and including termination of employment, as well as potential civil or criminal penalties.

8. HIPAA Training and Education Requirements

- I acknowledge that protecting patient privacy and maintaining the confidentiality and security of PHI are essential responsibilities of my employment.
- I agree to complete all required HIPAA Privacy, Security, and Confidentiality training provided by the Practice during orientation and within the timeframes established by the Practice.

- I understand that I am required to participate in periodic refresher training, annual training, updates, and additional education when changes in laws, regulations, technology, Practice policies, or job responsibilities occur.
- I agree to review and comply with all HIPAA-related policies, procedures, and protocols adopted by the Practice.
- I understand that if I have questions regarding privacy, security, confidentiality, or the appropriate use or disclosure of PHI, I am responsible for seeking guidance from my supervisor, Privacy Officer, Security Officer, or designated Practice representative before taking action.
- I agree to promptly report any actual or suspected privacy or security incident, breach, unauthorized access, use, or disclosure of PHI, regardless of whether I was personally involved.
- I understand that failure to complete required training or comply with HIPAA policies and procedures may result in disciplinary action, up to and including termination of employment.

Employee Training Acknowledgment

By signing this Agreement, I certify that I have received, or will receive within the Practice's designated onboarding period, training regarding:

- HIPAA Privacy requirements;
- HIPAA Security requirements;
- Patient confidentiality obligations;
- Appropriate access, use, and disclosure of PHI;
- Social media and electronic communications restrictions;
- Breach reporting and incident response procedures; and
- Applicable Practice privacy and security policies.

I understand that compliance with these requirements is a condition of my employment.

EMPLOYEE ACKNOWLEDGMENT

I acknowledge that I have read, understand, and agree to comply with the terms of this HIPAA Privacy, Confidentiality, and Social Media Agreement. I understand that my

compliance with these requirements is a condition of my employment and that violations may result in disciplinary action, up to and including termination of employment.

Employee Signature: _____

Printed Name: _____

Date: _____

Supervisor/Practice Representative: _____

Signature: _____

Date: _____

Personnel File Copy Required ☐ Yes

HIPAA Training Completed ☐ Yes ☐ Pending

Privacy Policies Provided to Employee ☐ Yes ☐ No

Please review the agreement with your legal or compliance advisors before implementation to ensure it aligns with your practice's specific policies and state requirements.