EMPLOYEE CONFIDENTIALITY AGREEMENT

I, _____, have read and understand the HIPAA Privacy Policies and Procedures of Suburban Health Consortium's group health plan ("Health Plan") with respect to Protected Health Information ("PHI") as necessary and appropriate for me, on behalf of my Employer, to carry out my duties and responsibilities with Health Plan, as required by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I agree that I will not at any time during my employment or association with Health Plan or Employer, or after my employment or association ends, use or disclose PHI except as required or permitted in the course of my duties and responsibilities with Health Plan, in accordance with Health Plan's HIPAA Privacy Policies and Procedures or as permitted under HIPAA. I understand that this obligation extends to PHI in any form, oral, written or electronic, and regardless of the manner in which PHI is acquired.

I further agree to cooperate with Health Plan in taking reasonable steps to cure any breach of this Agreement and any violation of Health Plan's HIPAA Privacy Policies and Procedures or HIPAA's privacy rules.

I understand that any unauthorized use or disclosure of PHI by me may result in disciplinary action, up to and including the termination of my employment or association with Health Plan or Employer, as well as the imposition of civil and/or criminal penalties and professional disciplinary action.

I understand the obligations and restrictions under this Agreement will survive any termination (regardless of the reason and whether voluntary or not) of my employment or association with Health Plan or Employer.

_____ Date_____

Signature

Employer:

_____

[name of school district]