



HIPAA ACKNOWLEDGEMENT FORM

As an independent contractor/business associate of Solvere, I understand and acknowledge that:

It is my legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all medical records, proprietary and other confidential information relating to the health or condition of an individual as required by the Health Insurance Portability and Accountability Act (HIPAA) federal law*.

I agree to access, use or disclose confidential information only in the performance of my duties, where required by or permitted by law, and only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.

I agree to discuss confidential information only for medically appropriate treatment and related purposes. I will not knowingly discuss any confidential information within the hearing of other persons who do not have the right to receive the information. I agree to protect the confidentiality of any medical, proprietary or other confidential information which is incidentally disclosed to me including: Psychiatric records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV.

As an Independent Contractor / Business Associate of Solvere, I understand that I have a responsibility not to participate in or condone any unwelcome conduct in the workplace that is based on an individual's age, ancestry, citizenship, color, marital or parental status, national origin, political affiliation, pregnancy, race, religion, sex or gender, perceived sex or gender, sexual orientation, military or veterans' status, physical or mental disability, medical condition, or the perception that a person is associated with a person who has or is perceived to have any of these characteristics.

As an Independent Contractor / Business Associate of Solvere, I have been advised that: Discrimination and harassment on any other basis protected by federal, state, or local law, ordinance, or regulation is prohibited.

Violation of any of the Health Insurance Portability and Accountability Act of 1996 and/or the Kennedy-Kassebaum Act policies and procedures related to confidential information or of any state or federal laws or regulations governing a patient's right to privacy may subject me to legal action.

Signature _____ Date _____

Print Name _____

*Full details of the HIPAA regulations can be found at: http://www.cms.gov/HealthPlansGenInfo/12_HIPAA.asp