HIPAA
EMPLOYEE CONFIDENTIALITY
AGREEMENT

____
Name

____
Address

____
City/State/Zip

____
Phone

Please confirm this statement and sign the following:

As a temporary Employee, my signature indicates that I have read "Dental Professionals HIPAA Training Policy for Temporary Employees". I understand that it is my responsibility to properly handle any confidential patient information, and that I am restricted from accessing, inspecting, using, or disclosing confidential information beyond the minimum required by each dental facility I work at to fulfill my contracted duties.

______________________________ ______________________
Signature **Date**