CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

I, _____ (name of employee, contractor, volunteer, or student) of the Tohono O'odham Nation Health Care (TONHC), understand and agree that it is the duty and policy of the TONHC to maintain the confidentiality of all patients and provider medical records and to protect each patient's right to privacy. I understand that the community trust of the TONHC require that such services and information be kept confidential. Programs require that such services and information be kept confidential. I understand that by the nature of my employment, I may come into possession of health or personal information concerning the services performed by the TONHC even if I do not take any direct part in or furnish these services.

I, _____ (the employee, contractor, volunteer, or student), have been trained by the Privacy Officer or designee regarding patient information and how to protect health information; and I agree that patient health information can be released only according to set policies and procedures and in accordance with federal and state law, regulation, and policy.

I have reviewed in detail the Confidentiality and Non-Disclosure Policy above and fully understand its content and directives. I recognize that the disclosure of such information may create irreparable injury to the TONHC, or to our patients or providers. I understand that any failure to comply with this policy will result in disciplinary action and may invoke a legal cause of action.

_____ _____

Print Name Date

_____ _____

Signature Hire Date

ANNUAL REVIEW (Date/Initials of employee/contractor/volunteer/student and respective manager):

Employee/Contractor/ Volunteer/Student Initials	Date	Manager/Supervisor Initials	Date