



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 “Nevada Dental Staffing 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