CARE STAFFING
Professionals

HIPAA
ACKNOWLEDGEMENT OF CONFIDENTIALITY OF PATIENT HEALTH CARE INFORMATION

I acknowledge the confidentiality of patient health care information (Confidential Patient Information) that I may receive or have access to while providing patient care services at participating hospitals and facilities at which I am assigned under the employment of Care Staffing Professionals. I shall maintain the confidentiality of Confidential Patient Information, and in doing so, shall comply with all applicable state and federal laws and regulations, including, without limitation, the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the policies and procedures of each participating hospital where I am assigned.

My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with Care Staffing Professionals and the conclusion of any assignment at any client facility at which I provide service.

Signature: _____

Print Name: _____

Date: _____

CSP Representative: _____

Email: _____

Title: _____