TEXAS J
Regional Advisory Council

TEXAS "J" REGIONAL ADVISORY COUNCIL
CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

I, _____, an Officer, Member, Participant, or employee of the Texas "J" Regional Advisory Council, acknowledge that I have an understanding of the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule)

- I understand that all patient information, including billing and financial data, is confidential.
- I agree to keep patient information confidential.
- I agree to comply with all TXJRAC Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subjected to disciplinary action up to and including termination of membership or employment.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I should speak with the TXJRAC Chair or Vice Chair.
- I understand and agree that the TXJRAC Policies and Procedures will apply to any patient information I have access to at the TXJRAC even after I terminate my membership or employment with TXJRAC.

Signature: _____

☐ If unable to sign check box and typing name will be signature

Name: _____

Organization: _____

Date: _____