



**State of Nebraska
Department of Health and Human Services**

**HIPAA/HITECH Business Associate Agreement
Exhibit A
Authorized Workforce Confidentiality Agreement**

This Agreement between _____ [name of *Business Associate*] and _____ [employee name], an employee or contracted agent of _____ [Business Associate] hereby acknowledges that the employee or contractor's records and documents are subject to strict confidentiality requirements imposed by state and federal law.

I [initial] ___ acknowledge that my supervisor, or whoever administers the data has reviewed with me the appropriate provisions of the HIPAA federal laws and applicable State of Nebraska privacy laws including the penalties associated with breaches of confidentiality.

I [initial] ___ acknowledge that my supervisor or whoever administers the data has reviewed with me the security policies of the Business Associate.

I [initial] ___ acknowledge that unauthorized use, dissemination or distribution of employer's Protected Health Information and confidential information is a crime.

I [initial] ___ hereby agree that I will not use, disseminate or otherwise distribute confidential records or documents containing Protected Health Information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I [initial] ___ also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with Business Associate and may subject me to penalties both civil and criminal.

Signed

Date: