



**MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH  
CONFIDENTIALITY AGREEMENT (“AGREEMENT”)**

I, [REDACTED], am an employee, **volunteer** or affiliate of the Maricopa County Department of Public Health ("MCDPH"). I understand that in the course of my work and experience, I may have access to and learn confidential patient and financial information obtained or maintained in oral, electronic and/or paper form. Examples of such information are medical condition and treatment, finances, social security numbers, phone numbers, addresses, living arrangements, employment, sexual orientation, relations with family members, etc. I also understand that I may have access to confidential information about the business and financial interests of the MCDPH. (All of the above is referred to as "Confidential Information" in this Agreement). I understand that Confidential Information is protected in every form, such as written records and correspondence, oral communications, and computer programs and electronic applications.

I agree to comply with all existing and future MCDPH policies and procedures to protect the confidentiality of Confidential Information. I understand and agree that the unauthorized disclosure of Confidential Information, including patient information, is a violation of Federal and State Law(s). I agree not to use, copy, make notes regarding, remove, release, or disclose Confidential Information unless it is permitted by MCDPH policy.

I agree not to share or release any authentication code or device, password, or identification badge to any other person, and I agree not to use or release anyone else's authentication code or device, password, or identification badge. I agree not to allow any other person, except those authorized by MCDPH, to have access to MCDPH information systems under my authentication code or device, password, or identification badge. I agree to notify the appropriate administrator immediately if I become aware that another person has access to my authentication code or device, password, or identification badge or otherwise has unauthorized access to or has disclosed MCDPH information systems or Confidential Information.

I agree that my obligations under this Agreement continue after my employment or my time as a volunteer or affiliate ends.

I have read and understand this agreement and I agree to maintain confidentiality for the Confidential Information to which I may be granted access. I understand that failure to comply may result in disciplinary action, up to and including dismissal. Additionally, I understand if I reveal Confidential Information without proper authorization, I may be subject to criminal and civil penalties or liabilities under state and federal laws for invasion of privacy.

**EMPLOYEE/AFFILIATE:**

**SUPERVISOR/PRECEPTOR REVIEW:**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

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**Date**