

HEALTH SOURCE GROUP, INC.

Confidentiality and Non-Disclosure Agreement (HIPAA)

I, _____, do affirm that I will not divulge DATA TO ANY UNAUTHORIZED PERSON FOR ANY REASON. Neither will I directly nor indirectly use, or allow the use of, **HSG CLIENT'S** data for any purpose other than that directly associated with my official assigned duties. I understand that ALL PATIENT INFORMATION, including financial data, is strictly confidential.

Futhermore, I will not, either by direct action or by counsel, discuss, recommend, or suggest to any unauthorized person the nature or content of any **HSG CLIENT** information.

Violation of confidentiality is cause for disciplinary action, including immediate dismissal.

I understand that signing this document does not preclude me from reporting instances of breach of confidentiality.

Signed _____ Date _____