{NAME OF YOUR BUSINESS}

{your name and contact info}

Vendor/Contractor
Business Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that all patient medical and financial information, records and data to which I come into contact with during the course of my business activities with {NAME OF YOUR BUSINESS}is to be kept confidential, and this confidentiality is a condition of my future business relationship with {NAME OF YOUR BUSINESS}. This information shall not be disclosed to anyone under any circumstances. In accordance to HIPAA regulations, I further agree not to sell, share, discuss, assign, transfer or otherwise disclose any confidential information other than for the purpose mutually agreed upon. Upon termination of this agreement, I shall return all information, unless acceptable arrangement for its destruction are made. The unauthorized disclosure of patient medical and financial information, records, and data is grounds for termination of any business activities with {NAME OF YOUR BUSINESS}.

Date: __________________

Business Name: ____

Signature of Authorized representative of business: ______________________________

Print Name of Authorized representative of business: ____________________________

Title of Authorized representative of business: __________________________________