PRIVACY ACKNOWLEDGMENT AND NON-DISCLOSURE AGREEMENT

Wilson Eye Associates, Optometrists, P.A. is committed to protecting the privacy of all patients and protecting the confidentiality of their health care information. While working with patients for Wilson Eye Associates, Optometrists, P.A., I realize that I may have access to or become aware of confidential patient medical information, in electronic or paper form, whether or not I am directly involved in providing care to that patient.

I understand that I must keep this information in the strictest of confidence. As a condition of my employment or work at Wilson Eye Associates, Optometrists, P.A., I agree that I will not verbally or in any written or electronic form disclose confidential patient information to any unauthorized person or permit any unauthorized person to examine or make copies of any patient's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at Wilson Eye Associates, Optometrists, P.A.. I also agree that I will not examine, use, or disclose confidential patient medical information except as needed to perform the duties of my job. I agree to abide by Wilson Eye Associates, Optometrists, P.A.'s policies with regard to the use of e-mail, electronic data storage devices, and Wilson Eye Associates, Optometrists, P.A.'s "Device and Media Controls" policy.

I understand that a violation of this agreement may result in corrective action, up to and including discharge or termination of my employment or work at or for Wilson Eye Associates, Optometrists, P.A..

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Signature

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Printed Name

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Position at Wilson Eye Associates, Optometrists, P.A.

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Date

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