

NJHA Registry Management Program

Attachment 8

**Sample Acknowledgement of Confidentiality of
Patient Healthcare Information**

I acknowledge the confidentiality of patient healthcare information (“Confidential Patient Information”) that I may receive or have access to in the course of providing patient care services at participating institutions at which I am assigned under the NJHA Registry Management Program. I shall maintain the confidentiality of Confidential Patient Information, and in doing so, shall comply with all applicable state and federal laws and regulations, including, without limitation, the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the policies and procedures of each participating institution where I am assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with (Insert Agency name here)_____ and the conclusion of any assignment at a participating institution under the NJHA Registry Management Program.

Agency Healthcare Provider Name

Agency Healthcare Provider Signature and Date