HIPPA CONFIDENTIALITY AGREEMENT

NAME_____

ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE NUMBER _____

I, _____, understand that my signature indicates that I will not share the following information to anyone outside of Southern Therapy Solutions Staff:

- Names of patients
- Ages of patients
- Diagnoses of patients
- Photos of patients
- Any and all things pertaining to patients

I understand that it is my responsibility to handle any confidential patient information, and that I am restricted from accessing, inspecting, using, and disclosing confidential information beyond the STS staff.

Signature _____ Date _____

Witness _____