Confidentiality and Nondisclosure Agreement

Name: _____
(Please Print - Last, First, MI)

Relationship to Mayo Clinic Health System - Northwest Wisconsin Region:

(Please Select One)

- ☐ Physician (Employee)
- ☐ Physician (Non-Employee)
- ☐ Employee
- ☐ Temporary Agency Employee
- ☐ Student
- ☐ Volunteer
- ☐ Other, please indicate: _____

I understand that in my relationship with Mayo Clinic Health System - Northwest Wisconsin Region (MCHS – NW WI Region) I will have access to information not generally available or known to the public. I agree that such information is confidential information that belongs to MCHS – NW WI Region. MCHS – NW WI Region's confidential information includes but is not limited to: patient, customer, member, provider, group, physician, employee, financial, and proprietary information, whether oral, observed or recorded in any form or medium. I agree that information developed by me, alone or with others, may also be considered confidential information belonging to MCHS – NW WI Region.

I will hold MCHS – NW WI Region's confidential information in strict confidence and will not disclose or use it except as authorized by MCHS – NW WI Region and for MCHS – NW WI Region 's benefit.

I will not access confidential information for which I have no legitimate business need to know. Only designated employees may release medical information with the proper written consent from the patient. The appropriate Vice President must approve release of organization information.

I understand that I am required to report any suspected breaches according to Confidentiality and Breach Notification Policy.

I understand that if I breach the terms of this Confidentiality and Nondisclosure Agreement, MCHS – NW WI Region may institute disciplinary action up to and including termination of my employment, service or association with MCHS – NW WI Region and in some instances civil and/or criminal penalties.

Signature _____ **Date _____**

Witnessed By: _____ **Date _____**