Organization/Employee/Contractor

Confidentiality and Security Agreement

Instructions: This form is required for each person being assigned an EMR password.

I understand that ________________________, for whom I work, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of the patients' health information. Additionally, the Organization must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information, with patient identifiable health information. In the course of my employment at the Organization, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Organization's privacy and security policies. I further understand that I must sign and comply with this Agreement as a continuing condition of my access to the system.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge copy, release, sell, loan, alter or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of Confidential Information.
5. I agree that my obligations under this Agreement will continue after my employment, expiration of my contract, or my relationship ceases with the Organization.
6. Upon termination I will immediately return any documents, or media containing Confidential Information consistent with the Business Associate Agreement.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Organization.
8. I will act in the best interest of the Organization and in accordance with its HIPAA compliance program at all times during my relationship with the Organization.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including suspension and loss of privileges, and/or termination of employment .
10. I will only access or use data, systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of personal privacy when using the Organization's information systems. The Organization/Hospital may log access, review and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures including but not limited to: logging off my computer when leaving and not divulging my password to any other person.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standard and requirements.
14. I will use only my officially assigned User ID and password and use equipment with officially approved software to do my job.
15. I will never import, download or install any unapproved software or applications or use tools, equipment or techniques to break/exploit software/systems/security measures.
16. I will notify the Practice's Privacy Officer or appropriate Organizational Authority if my password has been seen, disclosed or otherwise compromised, and will report activity that violates this

Agreement, privacy and/or security policies or any other incident that could have adverse impact on Confidential Information.

17. I will immediately report to the Organization's Privacy Officer or appropriate Organizational Authority any breaches of PHI of which I may become aware in accordance with hospital policy. (IM 18)
18. Upon termination:
    - I agree to notify Flagler Hospital within 24 hours, or the next business day, when members of my office staff are terminated, so that the user accounts to Organization systems are appropriately disabled in accordance with Organization standards.
    - I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Organization.
    - I will immediately return any documents or media containing Confidential Information to the Organization.

By signing this document, I acknowledge that I have read the Agreement and I agree to comply with all the terms and conditions stated above.

____ ____

Print Employee Name — Employee Signature

____ ____

Print Authorizing Manager Name — Authorizing Manager Signature

Provider/Business Entity Name:____

Date:__________________________________