HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: Employee Confidentiality Agreement **Effective Date: 9/1/2007**
Policy Number: Refer to HWP 105 **Med Staff:**
Regulation: HIPAA PRIVACY LAWS **Admin:**
Revised: 3/2016 by JP

I. POLICY
Refer to HWP 105

II. DEFINITIONS
An agreement between the hospital and the employee, volunteer, student and/or physician to maintain complete confidentiality of all personal, medical and corporate information.

III. RESPONSIBILITY
All staff.

IV. EQUIPMENT
N/A

V. PROCEDURES
INFECTION CONTROL: N/A
N/A

VI. DOCUMENTATION

I, _____, an employee or agent of Hardin County General Hospital and Clinic hereby acknowledge that Hardin County General Hospital and Clinic has a legal and ethical responsibility to safeguard the privacy and security of all patients and to protect the confidentiality of their private health information. Additionally, Hardin County General Hospital and Clinic must assure the confidentiality of it's corporate (human resources, payroll, finance, research, computer systems, management information, etc) information.

By signing this document, I understand the following:

1. I acknowledge that my supervisor, the human resource manager or a HIPAA team member has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality, understanding that a violation may subject me to the imposition of fines and penalties.
2. I understand that in the performance of my duties for Hardin County General Hospital, I must hold patient and corporate information in confidence. I also acknowledge that I am aware of the policies (included in the Employee Handbook and the Hospital-Wide policy and procedure manual) regarding confidentiality and security of health and corporate information including the access, use, collection, disclosure, storage and destruction of such information.
3. I understand if I have been provided with any personal access code such as a user ID or password to perform my assigned duties, I am responsible for all activity tied to

my password. If I believe my password has been breached, I will immediately notify my supervisor or my department head.

4. I agree not to disclose or discuss any patient, human resources, payroll, finance, research and/or management information with others, including friends, family or co-workers in person, by phone or social media who do not have a need-to-know.
5. I agree not to access or disclose any information (e.g. lab results, diagnoses, emergency room records, social security numbers, progress notes) or utilize equipment other than what is required to do my job.
6. I agree not to discuss patient, human resources, payroll, finance, research and/or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeteria, on public transportation, at restaurants or social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This is unprofessional and can raise doubts with patients and visitors about our respect for their privacy.
7. I agree not to make inquiries for other personnel who do not have proper authority or attempt to access a secured application/electronic or paper record without authorization.
8. I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
9. I agree to log off prior to leaving any computer or terminal unattended.
10. I agree not to make any unauthorized transmissions, inquiries, modifications, or purging of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from hospital's computer systems to unauthorized locations, e.g. home, cell phones or social media.
11. I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any user ID or password to be issued to me, this form must be completed. I further understand that computer access activity is subject to audit.
12. I understand that my obligations outlined above will continue after my employment or association with Hardin County General Hospital and Clinic ends.

_____ _____

Signature of Employee/Physician/Student/Volunteer Date

_____

Print Name

To be filed in Employee's Personnel Record