Confidentiality & Information Security Agreement

Erlanger Health System (EHS) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. While you are on the campus of any EHS facility, you may hear or read information related to a patient's health or see computer or paper files containing confidential health information, whether or not you are directly involved in providing patient services.

As part of your student shadowing and/or volunteer work with EHS, you agree to adhere to the following regarding confidentiality and security of patient information:

- ✓ *Confidential Health Information.* I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient's health, must be maintained in the strictest confidence. Except as permitted by this agreement, I will not at any time during or after my affiliation with EHS speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, except as allowed within my volunteer or shadowing duties.

- ✓ *Permitted Use of Patient Information.* I understand that I may use and disclose confidential patient information only to other EHS providers of health care services, if the purpose of the disclosure is for treatment, consultation, or referral of the patient. If my volunteer work allows, I may also disclose information for payment and billing purposes and/or internal operations, such as use for internal quality studies and for internal education activities.

- ✓ *Prohibited Use and Disclosure.* I understand that I must not access, use or disclose any patient information for any purpose other than stated in this agreement. I may not release patient records to outside parties. I must not access or physically remove records containing patient information from the provider's office, clinic, or facility, nor alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to health information without a legitimate, work-related reason.

  I also agree to immediately report to my supervisor or to the EHS Privacy Officer in the Compliance Department any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of confidential patient information that I see or know of others making that may be a wrongful disclosure.

- ✓ *Safeguards.* In the course of my volunteer work or student shadowing, if I must discuss patient information with other health care practitioners, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations. I understand that when confidential patient

information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this agreement.

Protecting the confidentiality of patient information means protecting it from unauthorized access, use or disclosure in any format—oral/verbal, fax, written, or electronic/computer.

- ✓ *Electronic Device Security.* I agree not to download identifiable patient information onto personally owned electronic devices. I agree to "secure" e-mail ("Confidential" in subject line) when sending patient information outside the Erlanger.org domain. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone, or allow anyone to access or alter information under my identity. I will back-up any confidential information using approved back-up procedures.

- ✓ *Social Media Use*. I agree to never post or store patient health information on social networking Web sites or transmit through peer-to-peer applications.

- ✓ *Physical Security.* I will take all reasonable precautions to safeguard *confidential* information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, encrypted laptops and electronic devices, etc. I agree to store my electronic media on approved institutional servers and store back-up media in approved locations.

- ✓ *Return or Destruction of Information.* If my affiliation with EHS requires that I take patient information off the EHS campus or off the property of the EHS affiliates, I will ensure that I have EHS's or the other facility's permission to do so. I will protect patient information from unauthorized access and/or disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

  Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

- ✓ *Termination.* When I leave my affiliation or complete my training or residency at EHS, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the EHS or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone, pursuant to EHS policy and NIST Standards. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.

- ✓ *Violations.* I understand that violation of this Acknowledgement may result in corrective action, up to and including termination of my affiliation. In addition, violation of privacy or security regulations could also result in fines or jail time.

- ✓ *Disclosures Required by Law.* I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if the EHS is complying with federal or state privacy laws.

  I understand that nothing in this agreement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

My signature, on the following page, acknowledges that I have read the terms and conditions of this Agreement and that I agree to abide by the terms of this Agreement. The signature page will be maintained by Human Resources.

Confidentiality Agreement
Signature Page

By my signature below, I acknowledge that I have read the terms and conditions of the Confidentiality Agreement and I will abide by the terms of the Confidentiality Agreement.

Signature: ____

Please circle *Student* *Intern* *Volunteer*

Printed name: ____

Date: ____

Phone Number: ____

Department: ____