F-IS-020.03 Confidentiality and Network Access Agreement Rev. 08/16 UNIVERSITY HEALTH CARE SYSTEM CONFIDENTIALITY & NETWORK ACCESS AGREEMENT

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Check	the	annro	nriate.	box

[] Employee of UHCS[] Med. Staff Physician (Employed)

[] Private Physician[] Employee of a Private Physician Practice

[] Student (Medical, Nursing, Ancillary)[] Other (Volunteer, Contract, Temp, etc.)

Organization/Location: _

Dept Name/#: _

As an authorized user of the University Health Care Integrated Computer System and having access to data stored within, I will be given sufficient access to perform my assigned duties. I will use this access ONLY for its intended purpose and I understand that the information accessed is considered confidential in nature.

THEREFORE, I affirm that I agree to the following:

- I accept responsibility to protect confidential information from inappropriate disclosure without regard to the method by which it was accessed. I understand that this information may concern, but is not limited to, patients, employees, operations, medical staff and business practices.
- I will not seek patient information unless I have a need to know the information in order to provide service to the patient or to the health care providers.
- I agree not to access my health record, except according to established policy guidelines.
- I will protect the privacy and confidentiality of all UHCS patients during and after my employment, affiliation, or volunteer service. I understand that this obligation extends to any organization or individual, including any person who may be an acquaintance, friend, co-worker, neighbor or relative of mine or the patient's.
- I understand that UHCS will routinely monitor and audit access to information regarding, but not limited to, employees and patients, their relatives, public figures and VIPs for appropriateness of access.
- I will maintain the confidentiality of any unique information systems access codes (user ID and passwords) assigned to me.
- I will sign off the computer when I leave the computer system.
- I understand that I am responsible for all activity logged under my password. I understand that I must log off before another user may use the computer.
- I agree to safeguard my unique information systems access code(s) to include my electronic signature code and I am strictly prohibited from disclosing these codes to any other person(s). I will not use another person(s) codes to access the system.
- I will contact my supervisor immediately if I suspect that knowledge of my unique information systems access code(s) has been gained by someone else. I understand the purpose of this notification is to protect confidentiality by having my unique information systems access code(s) changed.
- I understand that any breach of confidentiality may result in irreparable harm and may be subject to penalties by the federal government and other regulatory agencies.
- I will use the e-mail system in ways consistent with UHCS Electronic-Mail Policy.
- I will use the Internet access, if granted, in ways consistent with UHCS Internet Access Policy.
- I understand that if I breach confidentiality it will result in a loss of my privileges and for employees of UHCS it will result in disciplinary action up to and including immediate termination of my employment.

Signature

Date

Print Name (Full Legal Name)

Title or Position

Working Email Address (required for non-employees)

University Hospital Assigned ID, if known

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