UNIVERSITY HEALTH CARE SYSTEM

CONFIDENTIALITY & NETWORK ACCESS AGREEMENT

Check the appropriate 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