

Confidentiality and Non-Disclosure Agreement

University Physicians Healthcare (UPH) has an ethical and legal responsibility to protect the privacy of its patients and to maintain the confidentiality of their health information. UPH employees, physicians, volunteers, students in training programs, and vendors must make every effort to prevent unauthorized disclosure of medical, personal, or other data pertaining to patients, employees and UPH operations. Therefore, it is imperative as a condition of employment that each employee be familiar with and adhere to UPH Policy # A111, "Privacy/ Confidentiality of Protected Health Information" and UPH Policy # A110, "Release and Confidentiality of Corporate Information". Under no circumstances should patient information be released or discussed with anyone unless it is in the performance of legitimate job related duties. To ensure that all UPH employees acknowledge their responsibility to protect the integrity of corporate information and the privacy and confidentiality of patient information, please read and sign the following:

1. I acknowledge that all medical, financial and personal information is confidential and protected against unauthorized viewing, discussion and disclosure.
2. I further understand that this information is privileged and confidential regardless of format: electronic, written, overheard or observed.
3. I understand that I may view, use, disclose, or copy information only as it is related to the performance of my job duties. Any unauthorized viewing, discussion, or disclosure of this information is a violation of UPH policy and may be a violation of state and federal law. Any such violation may lead to my immediate termination and possible civil liability and/or criminal charges.
4. I agree to use the computer based information systems for the sole purpose of my legitimate job duties.
5. I agree not to use the computer based information systems to access information on myself, my family, or any other person outside the performance of my job duties.
6. I agree to follow all established policies in relation to changing, deleting, or destroying information in any form.
7. I understand that the passwords assigned to me to access computer based information systems are confidential and not to be shared with anyone under any circumstances.
8. I understand that any actions I take in the computer based information systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me.
9. I acknowledge that my signature on this Confidentiality/Non-Disclosure Agreement signifies I have read, understand, and am committed to its principles.
10. I understand that this signed and dated document will become part of my permanent personnel record.

Print Name

Volunteer Services
Dept/Title

UPH Hospital
Facility (Site)

Signature

Date