

STATEMENT OF CONFIDENTIALITY

It is Hospital Policy and law that all Hospital information is confidential. An employee, a member of the medical staff, volunteer, student or affiliate are agents of the Hospital and this statement applies to all agents. As an agent associated with the Hospital, you will have access to information and material relating to patients, employees, other individuals or the Hospital that is of a private and confidential nature.

1. The mission, principles and philosophy of the Hospital will be followed in accordance with the Hospital’s rules and standards of conduct. At all times you will respect the privacy and dignity of patients and their families, employees and all associated individuals.
2. You will treat all Hospital administrative, financial, patient, employee and other records, whether written, verbal or electronically stored, as confidential material and you will protect it to ensure full confidentiality. You will not access records, discuss or use such information unless there is a legitimate purpose to do so in your normal Hospital duties and responsibilities. All hardware, software and other equipment are to be used for business purposes only. The Hospital may conduct periodic audits to ensure compliance and to ensure data integrity.
3. Any system User-ID(s) issued to you and/or any Password(s) created and personally entered by you into Hospital Information Systems are unique codes to identify you to the Hospital Information Systems. All access/entries made will be associated with your identity. You will protect the security of your signature code and you will not use the code of another person, or enable another person to know or use your code.

Confidentiality is the right of every patient and everyone affiliated with the Hospital. Each of us is expected to respect that right. A breach of any of these conditions will result in disciplinary action up to and including termination of employment, loss of privileges, sanctions specified in applicable law, or similar action appropriate to your position with the Hospital.

I have read and understand the conditions outlined in this statement. I have also been made aware of the Hospital’s policies on security, privacy and confidentiality. I agree to abide by the Hospital Policy as a condition of my work with the Hospital.

Please indicate your Hospital agent type: Employee Medical Staff Volunteer Student Affiliate

AGENT NAME
(Please Print)

WITNESS NAME
(Please Print)

SIGNATURE

SIGNATURE

DATE

DATE

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Original Copy: Hospital File

