



## Confidentiality Agreement

I understand that Hospital Sisters Health System (“HSHS”), including its Local Systems and Affiliates, has a legal and ethical responsibility to safeguard the privacy and security of all patients and the confidentiality of their protected health information. This responsibility includes but is not limited to all data related to HSHS People Services, payroll, fiscal, research, computer systems, and any protected health information (“Confidential Information”.) Therefore, I understand my employment/assignment of services with HSHS is contingent upon my agreement that:

1. During the course of my employment/assignment with HSHS, I recognize that I may become aware of Confidential Information in verbal, written, or electronic form and that I may have additional responsibilities for protecting Confidential Information.
2. I will not disclose Confidential Information to unauthorized parties or access any Confidential Information not required to do my job. This means not accessing my own, my friends, my family, or co-workers Confidential Information without proper consent and authorization.
3. I will not share my personal access code(s), user ID(s), or password(s) or knowingly use or try to learn another person’s personal access code, user ID, or password for any reason.
4. If I have electronic signature capabilities, I certify that my user ID and password represent my signature and carry all the ethical and legal implications of a written signature. I will not disclose this password to anyone for any reason.
5. I understand that all of my actions on HSHS information systems, including HSHS provided email accounts, are the property of HSHS and are subject to audit without regard to my privacy.
6. I will lock or log off any workstation prior to leaving it unattended for more than 10 minutes.
7. I will not make any unauthorized transmissions, e-mails, inquiries, or modifications of Confidential Information. I will not remove any Confidential Information from any HSHS facility without proper authorization.
8. I will safeguard Confidential Information from intentional or unintentional unauthorized access, modification, loss, destruction or disclosure.
9. I will comply with all HSHS HIPAA Privacy and Security policies.
10. I will comply with the HSHS Colleague Social Networking policy.
11. I will immediately report to my supervisor, the HIPAA Privacy Officer, or the HIPAA Security Officer any activity that is a violation of this agreement or a violation of any HSHS HIPAA Privacy or Security policies.
12. I will immediately take steps to change my password if I have reason to believe the confidentiality of it has been compromised.
13. Upon termination of my employment or assignment with HSHS, I will immediately return any documents, equipment, or other media containing Confidential Information to HSHS. I also agree to turn over any keys, access cards, or any other devices that would provide access to any HSHS facility or its information.
14. I understand that my obligations under this Agreement will continue after the termination of my employment or assignment.
15. I understand that violation of this Agreement will result in disciplinary action, up to and including suspension, loss of privileges, and/or termination of employment or assignment and I may be subject to criminal and/or civil prosecution in the event I circumvent any of the above.

**My signature below acknowledges that I agree to and will abide by these provisions and that I will only access HSHS information systems for authorized patient care or business functions according to HSHS policies.**

\_\_\_\_\_  
First and Last Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Office Phone Number

This signed document is to be kept on file by People Services.