St. John's Hospital

Access and Confidentiality Agreement

Non-Employee / Third Party

This document is confirmation to St. John's Hospital that I am fully aware of the implications of access to the computer systems of the hospital and the confidentiality of the information to which I have access. I acknowledge that the data and/or information to be accessed will be patient medical record and health information that is confidential under law. I agree to maintain all such information in strict compliance with all applicable laws.

I understand that my login ID is the equivalent of my legal signature, and I will be responsible and accountable for all representations made at log in and for all work done under my login ID, including access by my employees, agents or associates whether authorized by me or not. I acknowledge that nothing in this agreement authorizes access to or disclosure of any records not otherwise permitted by law. I understand that the electronic data and information stored in the computer systems are confidential patient, financial, organizational, and practitioner data or information and must be treated with the same care as data and information in the paper records.

I will not access data for which I have no patient care responsibilities or peer review participation as defined in the Medical Staff bylaws and/or rules and regulations of St. John's Hospital, and warrant that my employees, agents and associates will not access data unless directed by me for assisting me with patient care responsibilities.

I will not disclose my login ID and password to anyone including my employees, agents or associates. I understand and acknowledge that unauthorized access to or disclosure of such information by me or my employees, agents or associates, may subject me to legal liability and/or cause St. John's Hospital to defend a legal claim. I understand that I am responsible for any unauthorized access to, or improper disclosure of, confidential information accessed by me or my employees, agents or associates. I agree to indemnify St. John's Hospital and to hold it harmless from any claim against it arising out of any unauthorized access to or improper disclosure of information by me or my agents or employees.

I understand that a password expiration time period may be applied to my account according to hospital policy that may require me to change my password according to a defined interval. If I believe the security of my login ID and password has been compromised or broken, I will immediately change my password and contact the Information Technology Department at St. John's Hospital.

I understand that the **Health Insurance Portability and Accountability Act** (HIPAA) provides for civil and criminal penalties for violation of HIPAA standards as follows: 1. civil penalties of $100 per violation up to $25,000 per year for all violations of an identical requirement. 2. Criminal penalties of $50,000 fine and one year in prison. 3. If the offense was committed under false pretenses, a $100,000 fine and five years prison. 4. If the offense was committed with intent to sell, transfer or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, a $250,000 fine and ten years in prison.

As a **physician**, I understand the misuse of my permitted access to the computer systems of St. John's Hospital and/or misuse of confidential information by me or my employees, agents or associates may subject me to disciplinary action, including, but not limited to, immediate termination of agreement to access, and further disciplinary action in accordance with the Medical Staff bylaws and/or rules and regulations of St. John's Hospital, up to and including termination of my medical staff membership and privileges, and the misuse or violation of confidentiality rules may also result in civil and/or criminal penalties. I may also be subject to criminal and/or civil prosecution if I allow my access privileges to be used to circumvent system security or confidentiality.

As a **physician's employee, agent, associate or student** it is my responsibility to maintain the confidentiality of all information that is entrusted to me. I am authorized to use only those login IDs and passwords that have been specifically assigned to me by St. John's Hospital. This login ID and password is the equivalent of my legal signature and is to be kept confidential. Access to employee, patient or financial information is permitted only as required for legitimate authorized purposes in the performance of my job as an employee, agent or associate of a physician with medical staff privileges at St. John's Hospital. I understand that if I violate any of these guidelines, my employer will be informed and I will be subject to having my access revoked. I may also be subject to criminal and/or civil prosecution if I allow my access privileges to be used to circumvent system security or confidentiality.

_____ _____ _____

Signature Printed name Date

Physician office\Institution name _____

PLEASE CIRCLE POSITION: PHYSICIAN / PHYSICIAN EMPLOYEE, AGENT, ASSOCIATE / STUDENT