Health Care District
PALM BEACH COUNTY

# CONFIDENTIALITY AND DATA SECURITY AGREEMENT

I understand that the District has a legal and ethical responsibility to safeguard the privacy of all patients. Additionally, the District must ensure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information (collectively with patient identifiable health information, "Confidential Information"). As an employee, student, volunteer, medical staff member, contractor, or other individual who performs services on behalf of the District or one of its entities, I understand that I must sign and comply with this Agreement to obtain authorization for access to Confidential Information. By undersigning below, I agree to the following conditions:

**The following statements apply to all individuals having authorized access to District systems.**

1. My username and password are the equivalent of my signature.
2. I am the only person authorized to use my username and password. I will not disclose my password to anyone or allow others to use my username.
3. I will choose a password which I can remember and that is difficult for others to guess.
4. I will not write my password where another individual may find it.
5. I will log out or secure my workstation whenever I leave the workstation unattended.
6. I will not use a workstation which has been logged onto by another user unless I log them out.
7. I will not attempt to learn another person's username/password and I will not attempt to access information using a username/password other than my own.
8. All information gained by my password will be treated as confidential and never be released to any person unless I have been authorized to release that information.
9. I understand that I will be held responsible for all actions which I allow to occur under my username or which occur due to my negligence.
10. I will only access and use Confidential Information when it is necessary to perform my job responsibilities in accordance with the District's Privacy and Security Policies.
11. I understand that the District maintains audit trails of access to information and system activity and that the audit trail may be reviewed at any time.
12. I understand the policy governing the use of the Internet and will comply with this policy at all times.
13. I will use all information gained through the computer systems (including electronic, paper, etc.) for the benefit of appropriate District Business.
14. I understand the need to protect the District's information both during my relationship with the District and after termination of my relationship. I will protect the confidentiality of all information that I use, originate, discover, or develop in the performance of my duties at the District.
15. I will not electronically copy or transmit Confidential Information not directly related to my authorized duties without specific written authorization from an authorized source.
16. I will participate in all future compliance, privacy, and security training requirements required of my position.
17. I will report any and all suspected privacy and security breaches in accordance with the District's HIPAA Breach Notification Procedures.
18. I understand that violation of this agreement may result in corrective action, up to and including immediate termination and/or legal prosecution and notification of law enforcement officials and/or state accreditation and licensure boards.

**Additionally, the following statements apply to all physicians using District systems containing patient identifiable health information.**

19. I understand that by accessing a patient's record, I am affirmatively representing to the District at the time of each access that I have a requisite business need to know and that the District may rely on that representation in granting such access to me.
20. I will ensure that only appropriate personnel in my office will access the District's systems and Confidential Information as authorized by me and in accordance with the District's policies and procedures. I will ensure that such personnel receive annual training on issues related to patient confidentiality and access.
21. I will accept full responsibility for employees who are granted access to systems and Confidential Health Information.

*Please complete as applicable.*

_____ _____ _____

Full Name (please print) Signature Date

_____

Department/Company

(Check all that apply): ☐ Healey Center ☐ Aeromedical ☐ Trauma ☐ School Health ☐ Primary Care Clinic

☐ Pharmacy ☐ Managed Care ☐ District ☐ Lakeside Medical Center

Relationship to the District: ☐ Employee ☐ Student ☐ Volunteer ☐ Medical Staff

☐ Other: (specify): _____

☐ Committee Member: List Committee(s): _____

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