ST. ELIZABETH HEALTHCARE ASSOCIATE CONFIDENTIALITY / NON-DISCLOSURE AGREEMENT

As a St. Elizabeth Healthcare associate, I am responsible for maintaining the confidentiality of information relating to patients/residents/clients and fellow associates. Unless it is necessary to complete my job responsibilities, information about the present condition, performance, or personal affairs of patients/residents/clients or other associates will not be repeated or discussed either inside or outside St. Elizabeth Healthcare.

When confidential information must be discussed in the course of my work, I will use discretion to keep such conversations from being overheard by others who are not directly involved. I am aware that there are both state and federal laws that protect health information and other confidential information from unauthorized access. I also realize careless or thoughtless release of confidential information can result in disciplinary action, including termination and also could result in legal action being taken against St. Elizabeth Healthcare.

As a St. Elizabeth Healthcare associate, I will be obligated to attend/complete training courses directed at ensuring my understanding of St. Elizabeth Healthcare privacy policies in relation to protecting confidential information.

Confidential information includes but is not limited to: (1) information about patient/resident/client's condition or treatment; (2) aggregate clinical data; (3) employee records; (4) employee patient/resident/client records; (5) marketing plans; (6) product or service plans; (7) strategies/forecasts; (8) patient/resident/client lists; and/or (9) financial information.

Confidential information can be obtained through hearing it, seeing it, viewing the medical record, or accessing it in the computer system.

While creating, accessing and/or utilizing confidential information I agree to abide by the following:

- I agree to keep confidential all information I access.
- I agree to access only the minimum necessary to perform my duty.
- I agree to access only that information for which there is a "Business Need to Know." I understand that my access may be monitored.
- I understand that I may not use the St. Elizabeth Healthcare computer system to access the medical records or financial records of myself, my children, my spouse, my neighbor(s), my co-workers or anyone, without a business based reason to do so. I also understand I may not look at paper records of any of these individuals without a business-based reason to do so.
- I agree to keep my password confidential. I understand that providing my password to another individual may result in disciplinary action up to and including termination.
- I agree to protect data at all times, which includes data in electronic, paper, film, images, video or other forms. I will protect data during its creation, entry, processing, distribution, storage, and disposal.
- I agree to protect data from unauthorized access, modification, destruction or disclosure.
- I understand that upon my termination from St. Elizabeth Healthcare my ability to access St. Elizabeth information will end. I agree that I will not attempt to access St. Elizabeth Healthcare systems or disclose any confidential information to any person or entity after my termination.

I have read this document and understand that my signature constitutes my acceptance of the terms of the "Confidentiality/Nondisclosure" agreement.

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Associate Name (Print) **Department**

_____ _____

Associate Signature **Date**

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Associate ID #