

Confidentiality Agreement

Concord Hospital and patients believe and expect that the privacy and integrity of health information will be preserved by all who use and maintain that information. I understand that each and every patient has the legal right to confidential treatment of their information. This means that any and all information regarding that patient not be disclosed to anyone that is not involved in that patient's current care. I then, have a legal duty to protect patient confidentiality and Concord Hospital business financial information. In the course of business, I may inadvertently come into possession of confidential information even though I may not be directly involved in providing patient services. For these reasons, my access to computerized and manually generated records is restricted. Accordingly, I pledge and assure that I will protect the patient's right to confidentiality of any and all medical and other information as well as Concord Hospital's business financial information

I AGREE:

1. I will access only those information systems that contain records that I must view, use, amend, disclose and/or copy in order to perform my job responsibilities.
2. I will not view, use, amend, disclose and/or copy any records, paper or electronic, which do not pertain to my job responsibilities.
3. I will not leave any such records or copies uncovered, unattended and accessible by unauthorized persons in my office or at my workstation, remote print stations, or any other location; or otherwise cause the disclosure of any such records or copies to any unauthorized third party.
4. I understand that access to all Concord Hospital information systems is a privilege and should be used with the utmost discretion. At no time am I authorized to use a Concord Hospital information system for other than its intended use or for my own or other's personal gain. I understand that my access and use of information may be monitored and audited to ensure appropriate access and usage.
5. My user identification plus my password to the hospital information systems is the legal equivalent of my signature. I will not disclose any of my user passwords to anyone. I will protect my passwords from use and discovery by others. In some circumstances, it may be necessary to provide those credentials to ITS staff in order to diagnose a reported system problem. Under those circumstances, the password must be reset upon completion of the diagnostic process.
6. Once I have logged in to an information system, I will not allow anyone else to use the information system to access patient, employee or business information.
7. I will not attempt to learn or use another user identification and password, other than my own, unless it is required in my role as an ITS staff member.

Privacy Agreement and Necessities Answer Form 2024-2025

8. I will never share patient identifiable, or other confidential information by telephone, e-mail or fax without understanding and using Concord Hospital approved methods for sharing confidential information in a secure manner.
 9. I will never post or discuss patient information using social media, such as Facebook, Twitter, and Instagram.
 10. If I have reason to believe that my user identification and password is known by others, lost or stolen, I will notify the ITS Help Desk immediately to have it reset. If I believe my user identification password has been used without my permission, I will report the violation to my Supervisor, Manager or Director.
 11. I know that I should change my passwords quarterly. I will do my best to create strong passwords by using a variety of at least 4 characters containing both alpha and numeric characters that do not follow a pattern or sequence or could be easily guessed by others.
 12. I will treat all Quality Assurance information as strictly confidential and I will not discuss or otherwise disseminate such information other than in the course of Quality Assurance and Process Improvement activities.
 13. I will report any privacy or security violations that become known to me to my Supervisor, Manager or Director.
 14. I understand that any privacy or security violations will subject me to sanctions up to and including termination. Willful privacy and security violations personally subject me to potential federal civil and criminal penalties.
-

Print Name (must be legible)

Date

Observer Signature

School if Applicable

Parent/Guardian signature if under 18

Unit/Dept at CH/CHMG

Necessities Answers

1. a b c d
2. a b c d
3. a b c d
4. a b c d
5. a b c d
6. a b c d