Laurens County Health Care System

1.20a EMPLOYEE CONFIDENTIALITY AGREEMENT

I (please print), *_____, an employment of Laurens County Health Care System hereby acknowledge that Laurens County Health Care System has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Laurens County Health Care System must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information. In the course of my employment at Laurens County Health Care System, I may come into the possession of confidential information. In addition, my personal access code, employee number and password(s) used to access computer systems is also an integral aspect of this confidential information.

By signing this document, I understand the following:

1. I acknowledge that my supervisor, the Privacy Officer, or the Security Officer has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breach of confidentiality.

2. I acknowledge that my supervisor, the Privacy Officer, or the Security Officer has reviewed with me the policies of confidentiality, privacy and security of our organization.

3. I agree not to disclose or discuss any patient, human resources, payroll, fiscal, research and/or management information with others, including friends or family, who do not have a need-to-know.

4. I agree not to access any information, or utilize equipment, other than what is
required to do my job, even if I don't tell anyone else.

5. I agree not to discuss patient, human resources, payroll, fiscal, research or

Administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.

6. I agree not to make inquiries for other personnel who do not have proper authority.

7. I agree not to willingly inform another person of my computer password or Knowingly use another person's computer password instead of my own for any reason.

8. I agree not to make any unauthorized transmissions, inquiries, modifications, purging of data in the system. Such unauthorized transmission include, but are not limited to, removing and/or transferring data from Laurens County Health Care System's computer systems to unauthorized locations, e.g. home.

9. I agree to log off prior to leaving any computer or terminal unattended.

10. I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any "USER ID" and/or PASSWORD to be issued to me, this form must be completed. I further understand that computer access activity is subject to audit.

_____

*Signature of Employee /Physician/Student/Volunteer/Chaplain

_____

*Print Name

_____

*Date