WORKFORCE MEMBER HIPAA AND CONFIDENTIALITY AGREEMENT

Reference Policy: AW1415

By my signature below, I hereby attest:

I understand that I may have access to patient protected health information (PHI) and confidential information about the business and financial interests of Summit Healthcare Association (SHA), collectively referred to as "Confidential Information" in this Agreement. I understand that Confidential Information is protected by both state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) in every form, including but not limited to, written records and correspondence, oral communications, and computer programs and applications.

I have watched the HIPAA Training Video: *What is a breach of PHI?* Accessible via https://youtu.be/hIrJS8WsX8A

I agree to comply with all existing and future SHA policies and procedures to protect Confidential Information.

I agree to not acquire, access, use, copy, make notes regarding, remove, release, or disclose Confidential Information, unless permitted by SHA policy.

I agree to protect SHA's Confidential Information, intellectual property, information and documents. I will not share, disclose, misuse or destroy Confidential Information without proper permission or unless permitted by SHA policy.

I agree not to share or release any authentication code or device, password, key card, or identification badge to any other person, and I agree not to use anyone else's authentication code or device, password, key card, or identification badge. I will not allow any other person to have access to SHA information systems under my authentication code or device, password, key card, or identification badge. I agree to notify the appropriate administrator immediately if I become aware that another person has access to my authentication code or device, password, key card, or identification badge, or otherwise has unauthorized access to SHA information systems or records.

I agree I will not access my own medical record, or a family member's record. I may access my medical information from the Health Information Management (HIM) Department or my provider's patient portal.

I will ONLY access patient records or discuss Confidential Information on a "Need To Know" basis as required to carry out my job functions. If I encounter a patient who is a friend or family member, I will immediately alert my supervisor. I will not access a friend's medical record unless there is a specific, job related need to do so and I am unable to hand off to a colleague or coworker. This includes treatment, payment and operations (TPO).

I will honor patient privacy and not reveal or discuss patient-related information, including but not limited to treatment, medical history, current health status, diagnosis, procedures, etc., except with the healthcare personnel directly involved in the patient's care.

I will not take videos or photographs on SHA premises. I will not use photos or other confidential information about my employment on social media without written permission from the Chief Executive Officer, Chief Marketing Officer, or their designee.

If I need to debrief and talk about a stressful incident in which I was involved, I will discuss the event only with my Director, manager, supervisor or lead, another person as assigned by my Director, or the EAP.

I agree that my obligations under this Agreement continue after my employment or my time as a volunteer, student or job shadow experience ends.

I agree that in the event I breach any provision of this Agreement or SHA policies and procedures, SHA has the right to implement disciplinary action or terminate my employment, volunteer status, student access or job shadow experience with or without notice at the discretion of SHA, and that I may be subject to penalties or liabilities under state or federal laws. I agree that, if SHA prevails in any action to enforce this Agreement, SHA will be entitled to collect its expenses, including reasonable attorney's fees and court costs.

Printed Name ____________________________________

Title or Role ____________________________________ Department ____

Signature ______________________________________ Date ____