WORKFORCE MEMBER HIPAA AND CONFIDENTIALITY AGREEMENT

Reference Policy: AW1415

By my signature below, I hereby attest and agree as follows:

- I understand that I may have access to patient protected health information (PHI) and confidential information about the business and financial interests, intellectual property, information and documents 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 will comply with all existing and future SHA policies and procedures to protect Confidential Information.

- I will not misuse and I will protect SHA's Confidential Information. I will not acquire, access, use, copy, make notes regarding, remove, release, share, or otherwise disclose Confidential Information, unless permitted by SHA policy. I will not destroy Confidential Information without proper permission or unless permitted by SHA policy.

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

- I will not access my own medical record. I understand I may only access my medical information from the Health Information Management (HIM) Department or my patient portal.

- I will ONLY access patient records on a "Need to Know" basis as required to carry out my job functions. I will not access a patient record, including but not limited to coworkers, friends, family members, etc. unless the access is needed to carry out my job duties. If I encounter a patient who is a friend or family member, I will immediately alert my supervisor to determine if I can hand off to another coworker or colleague. This includes treatment, payment and healthcare operations (TPO).

- I will honor patient privacy and ONLY reveal or discuss health-related information on a "Need to Know" basis with the healthcare personnel directly involved in the patient's care. This includes, but is not limited to treatment, medical history, current health status, diagnosis, procedures, etc., as it relates to TPO.

- 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, Marketing Coordinator, 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 Employee Assistance Program (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 _____ Employee # if applicable_____

Title or Role_____ Department_____

Signature_____ Date_____ Jan 2025