

MARSHALL UNIVERSITY
Joan C. Edwards School of Medicine
MarshallHealth
Workforce Confidentiality Agreement

I acknowledge that during the course of performing my assigned duties I will have access to, use or disclose confidential information (including patient, employee, medical staff, vendor, physician practice and business information). I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

- A. I will use and disclose confidential information only in connection with and for the purpose of performing my assigned duties
- B. I will request, obtain or communicate confidential information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential information than is necessary to accomplish my assigned duties
- C. I will take reasonable care to properly secure information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver in order to prevent access by unauthorized users.
- D. I will not disclose my personal password(s) to anyone without the express written permission of my department head or record or post it in an accessible location and will refrain from performing any tasks using another's password

I understand that as part of the workforce of a health care organization, the use and disclosure of patient information is governed by the rules and regulations established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Therefore, with regards to patient information, I commit to the following additional obligations:

- A. I will use and disclose patient information solely in accordance with the patient information policies set forth above, in the Employee Handbook or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.
- B. I will immediately report any unauthorized use or disclosure of patient information that I become aware of to the appropriate supervisor using the reporting procedure set forth in the Employee Handbook.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment.

Name (Please Print)

Signature

Date

Witness

Date