MARSHALL HEALTH NETWORK
CONFIDENTIALITY AGREEMENT

As an employee/student of the healthcare entity I have checked below, I may have access to protected health information ("PHI" within Marshall Health Network (MHN), for treatment, payment or healthcare operation purposes as those terms are defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as well as confidential and/or proprietary information about employees, the Hospital and the Hospital's business transactions and relationships.

Healthcare Facility (select applicable): _____ Cabell Huntington Hospital; _____ St. Mary's Medical Center; _____ HIMG;

_____ Marshall Health; _____ Rivers Health; _____ Other (print name): _____

As a condition of this access, I agree to the following terms and conditions, and acknowledge that violation of any of them shall be grounds for (i) loss of access; (ii) where applicable, disciplinary action up to and including termination of employment in accordance with applicable disciplinary policies; and (iii) where applicable, such actions that may be taken by the Office for Civil Rights, U.S. Department of Health and Human Services, in response to a complaint about a violation of HIPAA:

1. I shall keep confidential all PHI, regardless of whether it is oral, written or maintained in electronic media, and I shall use or disclose such PHI only as permitted by HIPAA or other applicable federal, state or local laws, rules or regulations. I shall also keep confidential all confidential and proprietary information about the Hospital and its business transactions and relationships.

2. I understand that my access to PHI within MHN shall be monitored, and I shall be held responsible for all attempts at access using my password regardless of who is attempting such access. Therefore, I shall always safeguard my password and not share it with any other individuals for any purpose or reason. Likewise, I shall not use another person's password to access PHI. I also shall log off any system that contains or provides access to PHI as soon as I am finished using such system, to prevent unauthorized access.

3. I understand that I may have access to PHI beyond what I need to carry out my specific job duties and responsibilities. I acknowledge that the fact that I may have access to such PHI does not authorize me to access such PHI in the absence of a legitimate reason to do so. Therefore, I shall limit access to PHI to what is specifically necessary to carry out my specific job duties and responsibilities.

4. I understand that access to PHI of Hospital employees as well as friends and family members is subject to the same use and disclosure requirements as access to any other patient's PHI. Therefore, I shall not access PHI of Hospital employees, friends or family members beyond what is specifically necessary to carry out my job duties and responsibilities.

I shall report any of the following to the Privacy Help Line immediately at (304) 399- 2997, mhnprivacyofficer@mhnetwork.org, in writing at MHN Privacy Officer, 2900 1st Avenue, Huntington, WV 25702.

a. If someone else's/ my own password is used by another person for access to PHI within MHN.
b. If I become aware of any unauthorized use or disclosure of PHI within MHN.
c. If I ever find that I have accessed any PHI within MHN in error.
d. If I am advised by a patient or family member of a potential unauthorized use or disclosure of PHI within MHN.

5. I shall keep confidential all employee information, (e.g. phone numbers, addresses, work schedules, etc.) regardless of whether it is oral, written or maintained in electronic media. I shall use or disclose employee information only as permitted within the scope of my employment.

6. I understand that my duties and responsibilities to maintain the confidentiality of information as described in this Confidentiality Agreement shall remain in effect even after my employment at the healthcare facility listed above ceases.

I understand that any violation of the Confidentiality Agreement or any HIPAA-related policy or procedure is grounds for disciplinary action, up to and including termination of my access rights and termination of employment.

Signature: _____ Date: _____

Print Name: _____

PES 7-27-07; 11-19-13; 8-16-17; 3-2-20

Non-Employee Attestation Form and Signature Page

(Completion of this document is required before an ID badge will be issued)

Name: _____ DOB: _____ Date: _____

Primary Source Verification – IF APPLICABLE (*Not applicable for the Student Job Shadowing Program)* I attest that I hold a valid WV professional license, certification or registration as required for the services I will be performing if required by law or regulation. I further attest that a copy of primary source verification can be provided before I initially begin performing services at Cabell Huntington Hospital and primary Source Verification is available before my license, certification or registration expires.	_____ initial
FIT Test (*Not applicable for the Student Job Shadowing Program*) I understand that in order to go into a room where a patient is on airborne precautions I must wear a special N95 respirator mask. I attest that I will not enter that area unless I have been fit tested at Cabell Huntington Hospital.	_____ initial

ALL APPLICANTS MUST RESPOND TO THE NEXT TWO STATEMENTS

Orientation and Confidentiality Agreement I attest that I have read and understand orientation materials and that my duties and responsibilities to maintain confidentiality as set forth in the Cabell Huntington Hospital Confidentiality Agreement shall remain in effect even after my access to PHI ceases.	_____ initial
Physical and Functional Status I attest that I have no physical or mental disabilities that would prevent me from performing services at Cabell Huntington Hospital.	_____ Initial

ALL APPLICANTS (EXCEPT THOSE WHO ARE COVERED BY AN AFFILIATION AGREEMENT THAT INCLUDES ALL THE FOLLOWING) MUST ALSO RESPOND TO THE NEXT TWO STATEMENTS

Criminal Background Check (*Not applicable for the Student Job Shadowing Program*) I attest that I have completed a background check and passed within the last 12 months.	_____ Initial
Drug Test (*Not applicable for the Student Job Shadowing Program*) I attest that I have taken and passed a 10 panel drug test within the last 12 months.	_____ Initial

ALL APPLICANTS

By signing this form I acknowledge that I have a continuing obligation to screen on a daily basis and to self-quarantine if any of my answers to the screening questions is "YES" and to inform my clinical supervisor. I further acknowledge that this is for my health and safety as well as the health and safety of my patients and co-workers. • Do you have any of these symptoms: fever, new cough, new shortness of breath, new body aches, new sore throat? • Are you currently in quarantine or have a test pending for COVID-19? • Have you had any close contact outside of clinicals with: A COVID-19 positive person or a person in quarantine or awaiting test results?	_____ Initial

ALL APPLICANTS (EXCEPT THOSE WHO ARE COVERED BY AN AFFILIATION AGREEMENT THAT INCLUDES ALL THE FOLLOWING) MUST ALSO PROVIDE EVIDENCE OF THE FOLLOWING:

• TB Test received within the last 12 months
• Influenza vaccination for the current flu season (October - March)
• Fully vaccinated for Covid-19
• Immunization records for the following:
  o Hepatitis B
  o MMR
  o Varicella
  o Tdap
These records will be reviewed by the CHH Occupational Health Department. I understand that I may be required to receive additional vaccinations and/or titers.
	_____
	initial

Release of Information & Attestation:

I authorize the use or disclosure of any health information listed on this page to Cabell Huntington Hospital. I understand that authorizing the use or disclosure of this health information is voluntary but may be a condition being able to perform services or otherwise conduct business with Cabell Huntington Hospital. Unless revoked, this authorization will be effective for no more than two years from the date signed.

I also attest that I have given correct information on this attestation form. I understand that if asked can provide verification of this information. I understand that providing false information will result in me no longer being able to perform services or otherwise conduct business with Cabell Huntington Hospital.

_____ _____ _____

Written Name **Signature** **Date**

User Identification and Information Technology Access Agreement

☐ NEW ACCOUNT ☐ RENEWAL ☐ DEACTIVATION ☐ MODIFICATION REASON: _____

Marshall Health Network, Inc. (MHN) and information technology users including employees, external users, faculty, students, volunteers, contractors, consultants, and vendors. All users are responsible for adhering to this agreement and all information security and privacy laws, policies, and contracts. Examples of such laws, policies, contracts, and licenses include Health Insurance Portability and Accountability Act (HIPAA); laws governing libel, privacy, copyright, trademark, obscenity, and child pornography; the Electronic Communications Privacy Act and the Computer Fraud and Abuse Act; and all applicable software licenses. By signing this document, you confirm that you are fully aware of the duties and responsibilities inherent in computer access and the confidentiality involved, which are included, but not limited to, the following statements:

1. I understand it is my responsibility to maintain the secrecy to all of my User Access Accounts and passwords so to prevent others from using my electronic signature, I will also not attempt to learn or use another individuals User Access Account and password.
2. I understand my User Access Accounts are equivalent to my legal signature (under West Virginia statutes), and I will be accountable for all work documented under these accounts.
3. I understand all Electronic Protected Health Information (ePHI) Information stored on a computer or device is confidential and must be treated to the same standard as health information in the patient chart. I will only access, use, or disclose an Individual's Protected Health Information (PHI) with whom I have a health care relationship; for treatment, payment processing, or other necessary business related to the patient in the performance of my duties.
4. Upon completion of work on any MHN owned device, I will ensure that my user accounts are "logged off" to prevent unauthorized use or otherwise lock devices when left unattended. I will keep mobile devices physically secured at all times and will not leave MHN devices in an unattended state such as restaurants, vehicles, airports etc…
5. I understand and agree that any misuse of any MHN and/or any of their facilities user accounts, systems and/or devices shall result in a violation and could subject me to disciplinary actions up to and including termination or result in cancellation of my access privileges.
6. I understand and agree that MHN and/or any of their facilities will not be held responsible for any harm that might occur as the result of me revealing my Account information to anyone, and that any breach of this agreement could result in criminal actions.
7. I will use caution with social media sites taking care to never disclose/post confidential information or photos (e.g., patient, financial, other employee, etc.) in any form. I will ensure that appropriate patient-provider boundaries are maintained with patients and their families.
8. Use of personal devices (e.g., laptop, phone, tablet, or other device) or services (e.g., DropBox, Google Docs, personal email, etc.) attached to any MHN and/or any of their facilities network or used for any MHN business must align with MHN policies. I understand that any device suspected to have contributed to a security incident may be confiscated, including personal devices.
9. I understand and agree that I will be responsible for keeping any personal device up to date with protection programs (antivirus, Spyware, etc) running on any personal system which may access MHN and/or any of their facilities network.
10. I understand and agree to hold MHN and/or any of their facilities harmless for any and all damages to any personal devices, hardware and/or software as a result of the electronic access, storing, retrieval or transmittal of information.
11. I understand that MHN and/or any of their facilities reserves the right to monitor, restrict or censor access to any and all of its systems.
12. At the time of departure from MHN and/or any of their facilities, whether through resignation or termination, I will be expected to return all organization-owned information, including but not limited to documents, electronic files, hardware, software, access cards, and any other assets containing organizational data.
13. If any of the following situations or issues arise, please contact the appropriate Information Services team.
    CHH (304) 526-2626, SMMC (304) 526-1267, HIMG (304) 528-4600 ext. 4425
    a. If there is any reason that someone has acquired and/or compromised my user account/password on any system, I will immediately change my password, if possible, contact Information Services or the appropriate System coordinator to have my password changed.
    b. I will immediately notify the appropriate IS support of changes required to my legal signature necessitated by changes in my name, job class and/ or qualifications.
    c. When using any hospital asset, I will abide by the software licensure agreement for each software application. If I should become aware of unlicensed software, I will inform the Information Services team immediately.
    d. I agree that in the event I have a change of status affecting my computer access requirements at my facility, I will inform the Information Services team immediately to either modify or delete my User Account, or if necessary to reset my password.

By my signature, I hereby certify and agree that it shall be my responsibility to ensure that the confidentiality of patient information is maintained at all times I understand and agree that all information submitted is accurate and will be for internal MHN and/or any of their facilities use only. Non-compliance has the potential of the following: (a) disciplinary actions by Marshall Health Network, Inc. and/or any of their facilities up to and including termination of employment or relationship with Marshall Health Network, Inc. and/or any of their facilities and (b) civil and criminal penalties imposed by either the federal or state government and/or supporting enforcement bodies and (c) civil and criminal litigation brought about by affected parties.

LAST NAME	FIRST NAME	MIDDLE
Birthdate (MM/DD/YYYY)	Start Date (MM/DD/YYYY)	Last 4 digits of SS#
E-mail Address	Phone Number	Department
Personal E-mail Address	Cell Phone Number	
Facility/Office/Company	Facility/Office/Company Address	Job Title

Are you or have you ever been an of Employee of MHN or any of their facilities? Yes ☐ No ☐ If yes, which facility _____
What was your User Access logon? _____ Access Requested _____ **Internal Use:** Non-employee access end date _____

Signature _____ Date _____