LUTHERAN HEALTH NETWORK

Confidentiality of Information, Computer Access Code, and Electronic Signature Agreement

For Associates, Board and Committee Members, Affiliated Professionals, Physicians, and Allied Health Professionals

As an Associate, Team Member, Board or Committee member, an affiliated professional or medical staff member with privileges at any Lutheran Health Network (LHN) facility or an Allied Health Professional with a scope of practice, I have the duty to protect the confidentiality of all patient, medical, financial, employee, organizational, and other types of information as outlined in this agreement or any LHN confidentiality policy. I also understand that each and every patient, visitor, guarantor, employee and other individual associating or interacting with LHN has the legal right to confidential treatment of information about himself/herself.

Therefore, any and all information I am exposed to in the course of performing my professional duties or which I come into contact within the course of my interactions with LHN shall be treated as highly confidential and shall not be disclosed to anyone who does not need that information to pertain his/her professional duties. Patient information should never be accessed or reviewed by anyone whose current professional duties do not require such access or review; furthermore, Professionals and other patient care personnel should never disclose patient information to anyone who is not directly involved in that patient's current care including, but not limited to the patient's spouse, family and relatives, friends, or other physicians or caregivers who treat the patient for other reasons without the patient's authorization.

Accordingly, I pledge and assure that I will protect the confidentiality of any and all patient, medical, financial, associate, organizational and other types of information to which I am exposed. This pledge of confidentiality applies to all sources of information and methods of communication including but not limited to computer systems, PDA's, paper documents, fax, email, telephone, direct verbal, and all other forms of communication.

I further agree that except as permitted or required by this Agreement or by law, I will not use or disclose patient information in a manner that would violate the requirements of 42 C.F.R. Part 2, known as "Confidentiality of Alcohol and Drug Abuse Patient Records, or 45 CFR Section 165.504 and 164-506(e), known as HIPAA Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which are incorporated herein by reference. I expressly agree to comply with HIPAA in all respects, including the implementation of necessary safeguards to prevent such disclosure.

Furthermore, if applicable, I acknowledge the following:

1. The combination of my user identification code and password to all hospital information systems is the legal equivalent of my signature. I will not disclose this code or password to anyone under any circumstances. I will not write or otherwise document my identification code or password where either may potentially be viewed by another individual.
2. Once I have signed onto any hospital information system, I will not allow anyone else to use the information system to access patient, medical, financial, associate, organizational, or any other type of information. When I leave the immediate physical vicinity of a PC or other device (whether in a LHN facility or a remote site) upon which I am signed into a system, I will ensure that I properly log out of the system. Use of my computer access code and password by anyone other than myself is forbidden under any and all circumstances.
3. I will not attempt to learn another user's identification code or password, nor will I use any identification code or password other than my own.
4. If I suspect or have any reason to believe that my identification code or password are or may be known by others, I will notify the Medical Staff Office or the Information Services Division immediately.
5. I understand that access to the hospital's information systems is a requirement for many positions within the organization and computer system access should be used with the utmost discretion. At no time am I authorized to utilize the system for any reason other than its intended use to perform my professional duties nor may I use it for my own or other's personal or professional gain.
6. If I have remote access to any of LHN's information systems, I will ensure appropriate security measures are implemented and maintained on the remote PC or device. Furthermore, I will ensure no patient data is downloaded or otherwise stored on the remote PC. I will take all reasonable and practical measures to minimize the risk of unauthorized access to LHN's systems. I understand that all terms and conditions of this agreement apply equally whether the systems are being accessed in any of LHN's facilities or from any remote sites.
7. I understand that only those individuals who have signed a "*Confidentiality of Information, Computer Access Code, and Electronic Signature Agreement"* will be given access to the hospital's information systems and only those authorized physicians or practitioners will be permitted to sign/complete medical record entries electronically.

I have read and fully understand the above and agree to be bound by each and every term and condition of this agreement as well as any Triad or LHN facility's confidentiality policy and the Medical Records policy regarding Electronic Signatures.

I understand that Physicians, as well as Allied Health Professionals and Affiliated Professionals, who are given access to hospital systems, are subject to a similar security and confidentiality agreement as hospital associates or agents. I further understand that hospital privileges for Physicians may be restricted or revoked in accordance with Medical Staff Bylaws if this agreement is violated either by the Physician, his/her employees, or the Allied Health Professional(s) he/she sponsors. Associates will be disciplined according to their specific facility conduct and discipline policy.

Printed Name: _____ Phone #/Extension: _____/_____

Signature: _____ Hospital Dept/Company/Employer: _____

AHP's Physician Sponsor Signature: _____ Date: _____
(Allied Health Professionals)