Ventura County Health Care Agency

CONFIDENTIALITY AGREEMENT

I understand that the Health Care Agency (HCA) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, HCA must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information (collectively "Protected Health Information").

In the course of my employment/assignment at the Health Care Agency (HCA),

Department: _____,
I understand that I may come into the possession of Protected Health Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of HCA's Protected Health Information.

1. I will not disclose or discuss any Protected Health Information with others, including friends or family, who do not have a need to know it. In addition, I understand that my personal access code, user ID(s), and passwords(s) used to access computer systems are also an integral aspect of this Protected Health Information.

2. I will not access or view any Protected Health Information, or utilize equipment, other than what is required to do my job.

3. I will not discuss Protected Health Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on the shuttle bus, on public transportation, at restaurants, and at social events). It is not acceptable to discuss Protected Health Information in public areas even if a patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.

4. I will not make inquiries about Protected Health Information for other personnel who do not have the proper authorization to access such Protected Health Information.

5. I will not willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.

6. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Protected Health Information in HCA's computer system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Protected Health Information from HCA's computer system to unauthorized locations (for instance, home).

7. I will log off any computer or terminal prior to leaving it unattended.

8. I will comply with any security or privacy policy established by HCA to protect the security and privacy of Protected Health Information.

9. I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of this Agreement or of any HCA information security or privacy policy.

10. Upon termination of my employment, I will immediately return any documents or other media containing Protected Health Information to HCA.

11. I agree that my obligations under this Agreement will continue after the termination of my employment.

12. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges, in accordance with the HCA's policies, as well as legal liability.

13. I further understand that all computer access activity is subject to audit.

By signing this document I understand and agree to the following:
I have read the above agreement and agree to comply with all its terms.

Signature of employee/physician/contractor/student/intern/volunteer:

_____

Print Name: _____ Date: _____

TO BE FILED IN PERSONNEL/CONTRACTOR FILE