THOMPSON
HEALTH

An Affiliate of the University of Rochester Medical Center

Access, Accountability and Confidentiality Agreement

As an Associate and/or an authorized computer system user at Thompson Health, I understand that during the course of my employment/association, I will be working with or have access to patient/resident and/or Associate information which is confidential. This information can be paper, or verbal; Protected Health Information (PHI); or computerized, Electronic Protected Health Information (EPHI). Federal and state statutes and regulations regarding the private and confidential nature of patient/resident records govern both PHI and EPHI. I understand that I have a legal and ethical responsibility to safeguard the privacy and security of all patients/residents, and Associates; and to protect the confidentiality of their private information regardless of format: paper, electronic or verbal. I further understand that I am responsible to make reasonable efforts to restrict the use, request or disclosure of PHI or EPHI to the minimum necessary to accomplish the purpose for which the information is being used.

By signing this document I understand the following:

1. I agree not to disclose or discuss any patient/resident, volunteer, physician, Associate Services, Payroll, fiscal, research and/or management information with other Associates, friends or family, who do not have a need to know.

2. I agree not to discuss patient/resident, Associate Services, Payroll, fiscal, research or administrative information anywhere others can overhear the conversation, for example: hallways, elevators, cafeterias, public transportation, restaurants, or at social events. It is not acceptable to discuss clinical information in public areas even if the patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.

3. I agree not to access any information, or utilize equipment, other than what is required to complete my work assignment.

4. I agree not to access information for other Associates/authorized users who do not have proper authority.

5. I understand that there is a process for obtaining access to my own records and it is my responsibility to follow the established process. I understand accessing my own record in any form without following the established process is a violation of Thompson Health policy.

6. I understand that accessing PHI/EPHI of a friend or family member is strictly prohibited. This violates Thompson Health HIPAA Security policies and procedures, IM.06.001 thru IM.06.018.00.01 and HIPAA – Minimum Necessary IM.03.028.

The follow apply specifically to Associates/authorized users with computer privileges:

7. I agree to log off prior to my leaving any computer or terminal unattended.

8. I agree not to willingly inform another person of my computer user ID or password, or knowingly use another person's computer user ID or password instead of my own for any reason.

9. I understand that all computer activity is subject to audit, and that I am responsible for computer activities to the terms of this agreement.

10. I agree not to make any unauthorized transmissions, inquiries, modifications, or purge data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Thompson Health computer systems to unauthorized locations, including home.

11. I understand should I have access to the internet, whether at my workstation or in a public access area, that Thompson Health specifically prohibits the use of the internet or other electronic communication services or equipment to access, download, or transmit materials that can be interpreted as pornographic, obscene, or otherwise in violation of Thompson Health policies concerning non-discrimination and harassment. All data residing on or transmitted through the Thompson Health electronic system is the property of Thompson Health. Please refer to Electronic Messaging policy # IM.01.008.002 @ http://ffth-ths/policies or in your Policy and Procedures manual if further explanation is needed regarding this policy.

12. I understand that as an Associate/authorized user with a Thompson Health e-mail address; I will not transmit EPHI via email unless otherwise authorized, and only if encrypted along with any attachments using encryption security, including responses to email received from patients. Should my position require transmission of EPHI, I will contact the IS Helpdesk for instructions on how to obtain authorization.

13. I have read, understand, and will comply with the HIPAA Security Workstation Use, Workstation Security, Transmission Security, and Device and Media Controls policies and procedures.

- ***I understand that lack of discretion or unauthorized disclosure of confidential information or misuse of computer system privileges is considered a major infraction of health system policy.***

- ***I understand that violation of this agreement may result in corrective action; suspension, loss of computer privileges, up to and including termination of employment and criminal prosecution.***

____________________________________ _____________
Associate/Authorized User Signature Date

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(Print Name)

We are proud to be an equal opportunity employer