



CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

I am: A physician, or allied healthcare provider, credentialed at Carroll Hospital Center.

[Check one]

A physician, or allied healthcare provider, NOT credentialed at Carroll Hospital Center.

An office staff employee of a physician, or allied healthcare provider, credentialed at Carroll Hospital Center.

An office staff employee of a physician, or allied healthcare provider, NOT credentialed at Carroll Hospital Center.

I am requesting access to confidential information owned or maintained by Carroll Hospital Center for use in the performance of my duties. I am requesting access to the following sources of information:

[Check one]

Patient Healthcare Information (also known as Protected Health Information: PHI, or Electronic Protected Healthcare Information: e-PHI)

Patient Financial Information.

Business information relating to Carroll Hospital Center (including financial, administrative, resource management, and other information)

PREAMBLE

Maintaining the confidentiality of all Patient Healthcare Information is the responsibility of Carroll Hospital Center and all of its employees, affiliates, healthcare providers, their employees and all persons who have legitimate, legal need to Patient healthcare information.

Misuse of Patient Healthcare Information is illegal and a violation of Carroll Hospital Center policies and procedures. It is the responsibility of anyone who signs this agreement to be knowledgeable concerning the Maryland law on the confidentiality of Patient Healthcare Information, HIPAA and the applicable Carroll Hospital Center policies and procedures.

Lack of knowledge or misunderstanding the legal or policy requirements regarding confidentiality of Patient Healthcare Information is never an excuse for violating the required confidentiality of Patient Healthcare Information.

It is never appropriate to access Patient Healthcare Information for personal reasons of curiosity or interest not directly related to the provision of healthcare services or billing for those services.

It is never appropriate to access Patient Healthcare Information for purposes of sharing or disseminating that information with, or to, anyone else not directly related to the care of the patient.

AGREEMENT

By signing below, I affirm and understand the implications of each item:

- a. I understand that approval to access and use this information in verbal, written, or electronic (stored in computer) form is a **privilege**. I also understand that access to Carroll Hospital Center information is permitted based only on business or clinical "need to know" standards and the responsibilities of my role as defined above.
- b. I agree to access information only on patients for whom I, my office, area, or department has responsibility. I understand that the methods I use to the requested information may only be used in the performance of my duties.
- c. If part of the information access privilege extended to me by Carroll Hospital Center includes the use of a computer workstation including the use of Internet or internal e-mail or Internet access, that I will exercise this privilege in accordance with the relevant policies and procedures of Carroll Hospital Center. I also understand that Carroll Hospital Center has provided access to the Internet for authorized users only to support the business purposes of Carroll Hospital Center.
- d. I understand that when granted a username and password that I accept full responsibility for any use or actions taken with my username and/or password; therefore I accept and affirm that I will not share my username or password with anyone else and will not leave a copy of either code accessible by anyone else. I will notify the Carroll Hospital Center HIPAA Security Office (ext. 7004 or the help desk x6809) should my code(s) be compromised in any way.
- e. I understand that I may not seek access to any information that is not required to perform my duties, even if I am able to get to that data. I understand that the use of my user access credentials, the patient or system accessed, and the date may be audited and reviewed by Carroll Hospital Center at any time, randomly or for cause, and that any unauthorized or uncorroborated use under my user access credentials may subject me to disciplinary actions noted later in this agreement.
- f. I understand that PHI accessed through the computer is considered the same as the accessing the patient's hard-copy medical record and may not under any circumstances be re-disclosed, without proper authorization, as defined in Carroll Hospital Center's Policies and Procedures. I agree to access, use, store and dispose of information, which I am exposed to in a way that ensures continued security and confidentiality, in accordance with Carroll Hospital Center Policies and Procedures and in accordance with all applicable state and federal law, including, but not limited to, HIPAA.
- g. I understand that Carroll Hospital Center has the right to modify, including revoking, user access at any time.
- h. I understand that actions taken for violations of this agreement may include but are not limited to:
 - i. Immediate termination of my electronic access to CHC data,
 - ii. Immediate termination of electronic access for all of those people associated with me in the same practice,
 - iii. Reporting the violation to appropriate state and federal authorities,
 - iv. Reporting the violation to the patient or patients involved,
 - v. Reporting the violation to the applicable licensing authority for you or your employer's healthcare practice (i.e., the Maryland Board of Physicians, the Maryland Board of Nursing, etc.),
 - vi. Reporting the violation to the Medical Affairs office of Carroll Hospital Center if you or your employer is a credentialed healthcare provider of Carroll Hospital Center,
 - vii. Reporting the violation to the Medical Affairs office, or other applicable credentialing office, of any hospital or healthcare entity where you or your employer is credentialed, or
 - viii. Legal action.

I acknowledge that I have reviewed the Carroll Hospital Center Confidentiality Agreement. My signature attests that I will abide by this Agreement.

Print Name: _____

Signature: _____ Date: _____

Practice Name/ Affiliation: _____ Practice Phone#: _____

Please briefly state your role and what information you need access:

If you are an Office Staff employee, this section MUST be completed.

I, the authorizing Physician or Office Manager, acknowledge the **Appropriateness and Acceptability** of this request for access to Protected Health Information by the above employee:

Print Name: _____

Signature: _____ Date: _____

Rev: 8/19/13