Confidentiality Agreement

It is the policy of Otsego Memorial Hospital and its affiliates (called "OMH" in this Agreement) that all employees, medical staff, students, volunteers, vendors, and any others who are permitted access, shall **protect and respect the privacy, confidentiality and security of all confidential information ("CI").**

CI includes: 1) patient information (such as medical records, billing records, and conversations about patients), and 2) confidential business information of OMH (such as information concerning employees, physicians, hospital contracts, financial operations, quality improvement, peer review, utilization reports, risk management information, survey results, and research).

I understand and agree not to share any CI learned through my observation experience.

Further, I agree that:

1. I will protect the privacy and security of OMH information.
2. I will not access the EMR.
3. I will not visit patients socially, for non- observation related reasons, without first obtaining their permission.
4. I will complete all required privacy and security training.
5. I will not maintain CI on a personal mobile device..
6. I will not enter a restricted area in hospital without an official observation related need or authorization.
7. I will not dispose of any paper or media with identifiable CI on it in the regular trash, but will use shredders, confidential bins or Information Systems to destroy materials.
8. I will immediately report to Human Resources any suspected privacy or security breach, or privacy error made in the course of normal scope of work.
9. I will safeguard all OMH and personal equipment from theft and improper use.
10. I understand that any OMH device may be audited, including access to medical records, use of email and websites, and, that there is no expectation of privacy.
11. I understand that I am responsible for complying with all OMH privacy and security policies.
12. I understand that all privacy breaches are investigated, documented and reported and that disciplinary consequences apply. Civil fines or criminal penalties may also apply.
13. I understand that my duty to maintain the confidentiality of information as described here remains in effect even after leaving the Hospital.

I have read and understand the information noted above.

Your Signature_____ Date _____

Print your Name _____

Witness Name: _____

Witness Signature: _____ Date: _____