

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

Security and confidentiality are matters of concern for all persons who have access to information from Memorial Hospital and Health System. Each person accessing any Memorial information including, but not limited to, patient, provider, administration, and financial information, holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information.

As a condition to receiving access to information, I, _____
agree to comply with the following terms:

- 1.) I will not at any time during or after my affiliation with Memorial disclose patient, business financial, or employee information to which I have access in any form (i. e. electronic media, paper, microfilm, verbal, etc.) without prior written consent of Memorial or unless required by law.
- 2.) I will not access or request information on patients (Protected Health Information), or any other confidential information including Memorial financial or personnel information, unless the access to this information is required by my job description.
- 3.) My computer login is equivalent to my LEGAL SIGNATURE and I will not share or disclose my login information, including user names or passwords, to anyone. In addition, I will not attempt to use another person's login and password. I am responsible and accountable for all entries made and all information accessed under my login.
- 4.) If I have reason to believe that another person knows my computer login, I will immediately follow the approved procedure for changing my password. I will also immediately notify the Security Administrator and/or my manager.
- 5.) I will secure access to the computer when not in use.
- 6.) I will respect the confidentiality of any reports and handle, store, and dispose of these reports according to Memorial policies and procedures. I will also respect the confidentiality of information stored on the computer, including any portable computers or devices I may work with.

I have read and understand the above Confidentiality and Non-Disclosure Agreement. I understand that my use of Memorial information will be monitored to ensure compliance with this agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action, including termination, civil or criminal action being taken against me, loss of access to information, or any other legal remedy available to Memorial. I accept my obligation to maintain the confidentiality of patient and provider information and agree to abide by the terms of the Agreement.

Signature: _____ Date: _____

Practice Site: _____

PLEASE FAX TO: MEMORIAL IS SECURITY (574)647-3062 WHEN COMPLETE