Mel Leaman Free Clinic at Emory & Henry College

601 Radio Hill Road • Marion, VA 24354
Tel: (276) 781-2090 • Fax: (276) 781-0866
http://melleamanfreeclinic.org

Employee/Workforce/Volunteer Confidentiality Agreement

I understand that the Mel Leaman Free Clinic has a legal and ethical responsibility to maintain patient privacy. Including protecting the confidentiality of patient information, and to safeguard the privacy of patients.

In addition, I understand that during the course of my service/affiliation/employment with the practice, I may see or hear other confidential information. For instance financial/operational data pertaining to the practice. I understand that the practice, and myself, have an obligation to maintain that data as confidential.

Confidential information is defined as ***all/any non-public information***; medical, financial, work-related and personal in any form *(written/oral/visual/electronic)* possessed *or* obtained by *either* party. This includes all information which:

A. *Either party has labeled as confidential* **B.** *Is identified at the time of disclosure as confidential*
C. *Is regarded as confidential in the health care industry* D**.** *Is Protected Health Information as defined by* ***HIPAA.***

ALL INFORMATION RELATING TO A PATIENT'S CARE, TREATMENT, OR CONDITION, CONSTITUES CONFIDENTIAL INFORMATION

As a condition of my service/affiliation/employment with the Mel Leaman Free Clinic, I understand that I must sign and comply with this agreement

By signing this document, I understand and agree that:

- I will disclose Confidential Information only if such disclosure complies with the practice policies, and is required for the performance of my job.
- My personal *access code(s), User ID(s), access key(s),* and *password(s),* used to access computer systems or other equipment are to be kept confidential at all times.
- I will not access or view *any* information other than what is required by my job description. If I have any question about whether access to certain information is required for me to do my job I will *immediately* ask my supervisor for clarification.
- I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear, *(E.g. hallways/elevators/largely public spaces).* I understand that it is ***not acceptable*** to discuss *any* patient information in common/open areas, even if specifics (*such as patient names)* are not used.

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- I ***will not*** make inquiries about any practice information for any individual or party who does not have proper authorization to access such information.
- I ***will not*** make unauthorized transmissions, copies, disclosures, and/or modifications *(e.g. adding/deleting)* of *any* Confidential Information. Such unauthorized transmissions include, *but are not limited to*, removing and/or transferring patient information from the practice computer system to unauthorized locations *(e.g. home, work).*
- Upon conclusion/termination of my service/affiliation/employment with the practice, I will *immediately* return all property *(keys, documents, ID badges, etc.)* back to the practice.
- I agree that ***my obligations*** under this agreement regarding *Patient Information will continue* even after the conclusion/termination of my service/affiliation/employment with the practice.
- I understand that violation of the agreement will result in ***disciplinary action***, up to and, including: termination of my service/affiliation/employment with the practice, or suspension/restriction/loss of privileges, in accordance with the practice's policies, as well as potential personal, civil, and criminal legal penalties.

I understand that any Confidential Information I access or view at the practice does not belong to me.
I have read the above agreement and will comply with all its terms as a condition of my service/affiliation/employment

_____ _____

(Print Name) **(Date)**

X _____

(Signature)