



CONFIDENTIALITY AND SECURITY AGREEMENT

As an associate, physician, health care provider, contractor, student of health care or temporary employee of Charleston Area Medical Center, Inc., I understand that I may have access to confidential information including patient, financial or business information obtained through my association with the Company. I understand that one purpose of this Agreement is to help me understand my personal obligation regarding confidential information. (See Information Services Information Policy: 9070.00 in the public folders or IS Dept Web site)

Confidential information regardless of media is valuable and sensitive and is protected by law and by strict Company policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), WV State law and other Federal Regulatory laws requires protection of confidential information contained within a health care information system. Inappropriate disclosure of patient data may result in the imposition of fines up to \$250,000 and ten years imprisonment per incident.

Accordingly, as a condition of and in consideration of my access to confidential information, I promise the following:

1. I will not access confidential information for which I have no legitimate need to know to perform my job/function and for which I am not an authorized user.
2. I will not in any way divulge, copy, release, sell, loan, review, gossip or speak in idle talk, alter or destroy any confidential information unless expressly permitted by existing policy except as properly approved in writing by an authorized officer of the Company within the scope of my association with the Company.
3. I will not utilize another user's password in order to access any system. I will not reveal my computer access code to anyone else.
4. If I observe or have knowledge of unauthorized access or divulgence of confidential information I will report it immediately either to my supervisor, the Privacy Officer or the Compliance Hotline.
5. I will not seek personal benefit or permit others to benefit personally by any confidential information that I may access.
6. I will not discuss any information regarding patients in common areas such as elevators and cafeterias, snack bars or smoking areas.
7. I will respect the ownership of proprietary software and not operate any non-licensed software on any Company computer.
8. I understand business communication is on approved systems only and it is my responsibility to encrypt business confidential and sensitive information prior to transmitting over public networks. I understand that all activity on the Company network and systems is subject to audit.
9. I agree to abide by all Company rules and regulations applicable to confidential patient information.
10. I understand that my failure to comply with this Agreement may result in disciplinary action, which might include, but is not limited to, termination of employment with the Company and/or loss of my privileges to provide services in the Company facilities.

By signing this agreement, I acknowledge that I have read or have had read to me and understand that The Company has an active on-going program to review records and transactions for inappropriate access and I understand that inappropriate access or disclosure of information can result in penalties up to and including termination of employment and/or legal action.

Signature

Date

Printed Name

CAMC

VOLUNTEER SERVICES

46830

Division

Department Name

Department Number