



PHYSICIAN OFFICE STAFF CONFIDENTIALITY STATEMENT

I, _____ agree to the following guidelines

1. Will respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for performance of my job;
2. Understand that the information contains sensitive and confidential patient information and should only be disclosed to those authorized to receive it;
3. Will not exhibit or divulge the contents of any record or report except to fulfill a work assignment;
4. Understand that I may **not** access health information on myself. I must have specific permission to access information on myself, my spouse, children, friends, neighbors and other physicians or employees. To access this information, I will contact the Health Information Management Department;
5. Will not release my user identification code or password to anyone, or allow anyone to access or alter information under my identity;
6. Understand that I am responsible for logging out of the system and will not leave unattended a display device to which I have logged on;
7. Understand that all access will be monitored;
8. Will not attempt to access information by using a user identification code or password other than my own;
9. Will not remove any records, reports or copies from their storage location except in the performance of my duties;
10. Report any violation or confidentiality or computer usage policies;
11. Respect the ownership of proprietary software (example, I will not operate unlicensed software on company computers or make unauthorized copies of such software for my own personal use;
12. Respect the finite capability of the systems, and limit my use so as not to interfere unreasonably with the activity of others;
13. Abide by the procedure established to manage the use of the system;
14. Will only make incidental personal use of these resources;
15. Will not use these resources to engage in illegal activities, or harass anyone;
16. Prevent unauthorized use of information maintained, stored or processed by the company;
17. Will not seek personal benefit of or permit others to benefit personally by any confidential information or use of equipment available through my work assignment;
18. Understand that my obligation under this agreement will continue after my termination of employment and that my privileges are subject to periodic review, revision and renewal; and
19. Understand that violation of this agreement will be denied access to the system, subject to disciplinary action, including termination and may be subject to penalties under state and federal laws and regulations

I further understand that my User Identification Code will be deleted from the system if I am no longer employed by

_____. (Physician Office or Group)

Should I return and require a new User Identification Code, a new code will be issued.

Signature

Date

Printed Name

Physician Signature