



## Hospital Orientation Acknowledgement/Agreement (non-employee)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

College/Dept./Company: \_\_\_\_\_ Date: \_\_\_\_\_

### Hospital Orientation

By signing below, I verify that I have read the Southeast Health Hospital Orientation material.

### Information Confidentiality & Non-Disclosure Agreement

The undersigned agrees and commits to the following statement:

Southeast Health expects that all individuals who have been granted authorized access to Confidential Information will use the information in a manner consistent with regulatory requirements, laws, and established policies and procedures related to the transmission, use, and disclosure of Confidential Information and security of information systems and data.

I understand and agree to adhere to the following:

1. All information related to a patient's past, present, or future healthcare and treatment in any facility, department, or unit of Southeast Health is considered "**protected health information**" (PHI). This information can only be accessed and shared with those who have a "**need to know**" while performing duties related to treatment, payment, and healthcare operations ("TPO"). While performing my duties, I agree to access only the minimal amount of information necessary to perform my job duties.
2. I will not use, disclose, or discuss PHI outside of Southeast Health unless specifically authorized in writing by the patient; permitted by the HIPAA Privacy Rule; or required by law. If I have any questions about the appropriateness of disclosure, I will ask the appropriate supervisor or the HIPAA Privacy Officer prior to disclosure.
3. I will not discuss patient information openly in a public environment, such as elevators, corridors, hallways, cafeterias, or at any other location where others may overhear comments. Discussions necessary for the care of the patient will be conducted as discreetly as possible.
4. Only authorized personnel may release copies of the patient's medical record and only in accordance with Southeast Health policy and consistent with state and federal regulations. I will not remove from my work area or from the facility any patient information, such as name, date of birth, address, and/or social security number, in any format (written, electronic, or verbal). **I will not copy patient information for personal or school-related use.**
5. If I am not personally responsible for handling telephone inquiries concerning a patient's condition, I will refer the caller to individuals who are authorized to respond to such inquiries. I understand that disclosure of PHI over the telephone must reasonably ensure protection of the information, to the greatest extent practicable, without interfering with the intended purpose of the communication.



6. I will be the sole user of my user identification code (user ID) and password in connection with my authorized access to information. I will take all necessary steps to prevent anyone from gaining knowledge or use of my password. I understand that my password is recognized as my personal signature on each computer function.
7. I understand that inappropriate use of or failure to maintain the confidentiality of any computer password will be cause for disciplinary action.
8. I am responsible and accountable for all entries made and all records retrieved under my username and password.
9. I acknowledge that e-mail communications, computer systems, and any other information resources are not private and may be monitored by Southeast Health to ensure that there is no unauthorized use of the company's systems. I also acknowledge that use of Southeast Health information and communications resources for illegal purposes or in violation of the law; or, to convey offensive harassing, vulgar, or threatening information, including disparagement of others based on race, national origin, marital status, sex, sexual orientation, age, disability, pregnancy, religious or political beliefs, or any other characteristic protected under federal, state or local law, is strictly prohibited and can result in termination.
10. I will ensure that Anti-Virus software is installed or removed only by authorized Information Systems ("IS") department staff on any Southeast Health computer or information system. I understand that I am not authorized to bypass this step.
11. I will sign off and/or physically secure a terminal or computer when leaving it unattended in an area open to unauthorized individuals.
12. I will not load copyrighted software, shareware, and/or freeware (software programs that are not protected by copyright) on any IS computer without prior approval by the IS department.
13. I will protect terminals, network devices and personal computers from theft and physical damage.
14. I will follow the process established for patients to access patient records and accounts, and I will not access patient records or accounts for myself or family.
15. I will protect from loss or theft any Southeast Health mobile device, to include laptops, PDAs, or storage medium (such as CDs, thumb drives, USB sticks), assigned to me or in my possession. Should such a loss or theft occur, I will immediately report it to the Southeast Health IS Help Desk at 793-8088 and to Southeast Health Security.
16. I will report any suspected HIPAA violation to my supervisor or the Southeast Health Privacy Officer.
17. I understand that violations of security and/or privacy rules and P&P's, whether due to carelessness or malicious intent, are causes for appropriate corrective action in accordance with HR P&P's, up to and including termination.
18. I acknowledge that my obligations and responsibilities continue after termination of employment, contract or affiliation with Southeast Health. **I understand this agreement will not expire.**



19. I acknowledge my access privileges are subject to periodic review, revision, renewal, or revocation and that I am obligated to maintain the confidentiality of any new information or systems I am granted access to in order to perform my specific job responsibilities.

### **Compliance Code of Conduct**

**The undersigned agrees and commits to the following statement:**

Ethical conduct is the highest form of loyalty to Southeast Health. We at Southeast Health have always taken pride in the ethical conduct of our employees -- in their honesty, their fairness, and their integrity. The success of Southeast Health depends on such behavior. It makes us more economically efficient, makes working with one another more enjoyable, and enhances our reputation with our customers and the public at large.

Part of being an ethical employee means carefully following all rules, laws, and regulations that govern your job and your work place. Therefore, it is Southeast Health's policy that you must learn about and conscientiously follow the laws and regulations that affect your job. It is very important that you learn and fully understand these rules and carefully read any written instructions that you receive in the course of your job. If you have questions, please ask your supervisor. Finally, because we at Southeast Health work as a team and because as a team we rely upon one another and are responsible for one another, it is also Southeast Health's policy that you shall report to your superiors if you become aware of any possible violation of any rules and regulations.

By signing below, I acknowledge that I have read the above Compliance CODE OF CONDUCT, that I agree to abide by it and will report any issues of which I am aware.

### **Chest Pain Center and Stroke Center**

**The undersigned agrees and commits to the following statement:**

I agree to be an Ambassador for the Chest Pain & Stroke Program by getting help for anyone in distress.

### **Expectations**

I understand that if I violate any policy, procedure or guideline of Southeast Health that I could be dismissed from clinical rotations at Southeast Health and this could also impact future employment opportunities.

\_\_\_\_\_  
**Signature of Full Legal Name**

\_\_\_\_\_  
**Printed Full Legal Name**

**Date:** \_\_\_\_\_