☐ By checking this box and typing my signature on the following Madison County Health Department Workforce Confidentiality Agreement Form, I am electronically signing this document.

Madison County Health Department – September 23, 2013
Workforce Confidentiality Agreement

I understand the Madison County Health Department (a.k.a. Department) has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality and safeguard the privacy and security of identifiable Protected Health Information (PHI) and other patient and Department information.

As a member of the Department's workforce*, I understand that I may see, hear or otherwise come into contact with PHI, and other confidential patient and Department information, such as financial data and operational information pertaining to the Department, that I am obligated to maintain as confidential. *(*Workforce includes full and part-time employees; volunteers; appointees; students; and other individuals engaged by or otherwise responsible to the Department, who are involved directly or indirectly in performing the Department's responsibilities.)*

To be a member of this Department's workforce, I understand I must sign and comply with this agreement.

By signing this document, I understand and agree to the following:

I will only disclose Protected Health Information, patient and/or other confidential information if such disclosure complies with the policies of Department, and is required for performance of my responsibilities.

I will keep my personal access code(s), user ID(s), access key(s) and passwords(s) used to access computer systems and/or other equipment confidential and secure at all times.

I will not access or view any information other than what is required to perform my responsibilities. If I have any question about whether access to certain information is required, I will immediately ask my supervisor for clarification.

I will not discuss any PHI and/or other information pertaining to patients and/or the Department in an area where unauthorized individuals may hear such information (i.e. in hallways, on elevators, in the lunch room, on public transportation, at restaurants, at social events, etc.). I understand it is not acceptable to discuss any such information in public areas even if specifics such as a patient's name are not used.

I will not make inquiries about any PHI, patient and/or Department information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purge any PHI, patient and/or confidential information from Department records or systems. Such unauthorized transmissions include, but are not limited to, removing and/or transporting such information from the Department's computer system or paper filing system to unauthorized locations (for instance, home), without explicit permission from an authorized manager or supervisor. I will not store any PHI on mobile devices (such as smart phones or laptops) that leave our location without explicit permission from an authorized manager or supervisor.

I understand any PHI, patient and/or Department information I view does not belong to me.

Upon termination of my association with Department, I will immediately return all property such as keys, documents, etc. to the Department. I will also surrender any access code(s), user ID(s), passwords, etc. used to access computer systems and/or other equipment.

I agree that under terms of this agreement, after leaving the Department's workforce, my legal and ethical obligations regarding protection and confidentiality of PHI, patient and/or Department information will not end.

I understand any violation of this Agreement may result in disciplinary action, up to and including termination of my responsibilities with Department; and/or potential personal, civil and criminal legal penalties.

I have read the above and agree to comply with all its terms and conditions.

Signature of Workforce Member	Date
Print Name	
Madison County Health Department Representative	Date