**Western Carolina University**

**CONFIDENTIALITY / SECURITY AGREEMENT**

**Introduction:**

Western Carolina University manages and maintains various information systems that contain confidential information pertaining to patients, health care professionals, and the organization. Departments such as University Health Services, Counseling and Psychological Services, Athletics, and Speech and Hearing Services maintain patient health records. This information is a major asset to those departments and is required by federal law to be protected. The use of a computer network that is shared by many individuals imposes many obligations, as well as potential security threats. A task of the WCU confidentiality/security policy is to inform individuals who use computer resources of their responsibilities and to secure their agreement to abide by the associated policies and procedures. This agreement covers all (paper, fax, electronic, phone, verbal, etc.) of protected health information.

THE AGREEMENT:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

EMPLOYEE NAME

**WILL NOT:**

* Exhibit or divulge the contents of any records or report except to fulfill a work assignment or as require by law
* Attempt to access information by using a user identification code or password other than my own
* Remove any records, reports, or copies from their permanent location except in performance of my duties
* Remove any records, reports, or charts from Health Services
* Release my user identification code or password to anyone, or allow anyone to access or alter information under my identity
* Use these resources to engage in illegal activities or harass anyone
* Allow unauthorized use of information maintained, stored, or processed by Health Services
* Seek personal benefit of or permit others to benefit personally by any confidential information or use of equipment available through my work assignment

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EMPLOYEE & SUPERVISOR INITIALS

**I WILL:**

* Only disclose information to those authorized to receive it
* 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
* Report any violation of confidentiality or computer usage policies
* Respect the ownership of proprietary software
* Limit my use of the computer network so as not to interfere unreasonably with the activity of others
* Abide by all the procedures and policies established to manage the use of the system

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EMPLOYEE & SUPERVISOR INITIALS

**I Understand:**

* That the information accessed through all of WCU patient information systems contains sensitive and confidential patient, business, financial, and employee information
* That I may access health information on myself, but must have specific authorization to access information on anyone else (e.g. my spouse, friends, neighbors, and other physicians or employees)
* That I am responsible for logging out of information systems and will not leave unattended a display device to which I have logged on
* That all access to systems that maintain patient protected health information will be monitored
* That my user id code and password are the equivalent of my signature and that I am accountable for all entries and actions recorded under them
* That my obligation under this agreement will continue after termination of my employment and that my privileges are subject to periodic review, revision and renewal
* That violators of this agreement will be denied access to information systems, subject to disciplinary action including termination and may be subject to penalties under state and federal laws and regulations.

**UNDER FEDERAL LAW THE EMPLOYEE WILL BE HEALD PERSONALLY ACCOUNTABLE FOR BREECHES OF CONFIDENTIALITY AND MAY BE SUBJECT TO CIVIL ($100-$250,000 PER INCIDENT) AND CRIMINAL (1-10 YEARS IMPRISONMENT) PENALTIES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EMPLOYEE INITIALS

By signing this, I agree that I have, understand, and will comply with this agreement and all associated policies and procedures.

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SIGNATURE

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DATE

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PRINTED NAME

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JOB TITLE

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WITNESS