MONUMENT HEALTH

Confidentiality Agreement

Monument Health (MH) is committed to protecting the confidentiality and security of patients' protected health information (PHI) and MH's sensitive business information.

As a condition of my employment or other affiliation including medical staff, independent contractor, vendor, volunteer, intern, observer or student I am required to read, agree and comply with terms of this agreement. Nothing in this agreement shall prohibit employees from engaging in protected concerted activity permitted by the National Labor Relations Act § 7 (29 U.S.C §157).

PHI is information in any form (e.g. electronic, written, and spoken/heard) that can be used to identify a patient including demographic information (e.g. patient name), financial information (e.g. insurance company) and health information (e.g. diagnosis code, x-ray). MH's sensitive business information includes, but is not limited to: 1) business plans or financials of any MH facility; 2) employee or job applicant information; 3) peer review or quality of care information or 4) passwords.

My disclosure of confidential information may cause irreparable injury to an individual, and/or to MH, which might result in civil action against me by harmed individuals or entities. I understand MH's liability insurance might decline coverage for me in the event I am sued for breaching confidentiality. I understand MH might refuse to indemnify me for the unauthorized disclosure of confidential information.

I understand I have a responsibility to protect the privacy and security of PHI and confidential information and I agree with the following:

- To follow MH policies and procedures regarding use and disclosure of PHI and confidential information.
- To take all reasonable precautions to safeguard confidential information. Some of these precautions include not sharing my password with others, locking or logging out of the computer when I leave, shredding documents that contain PHI and confidential information, turning over unattended documents that contain PHI and confidential information.
- To ask my supervisor if I have any questions about whether a use or disclosure of PHI and confidential information is permitted.
- To only request or access the minimum amount of information that I need to do my job. This does not include accessing my own, my family or my friends' medical records.
- To only discuss PHI and confidential information with individuals who need the information to do their job. I understand the presence of a patient/resident at a MH facility or ability to pay their bill is considered PHI and cannot be used or disclosed unless there is a "need to know."
- To recognize my surroundings and only discuss PHI and confidential information in an area where there is a low risk that individuals without a need to know may overhear. I will use a low voice when there is a possibility that an individual may overhear my conversation.
- To not discuss PHI and confidential information in public (e.g., social media, internet blogs, cafeterias, restaurants, social events) even if specifics such as names are not used.
- To use PHI and confidential information only in ways that could be interpreted as in the best interest of MH.
- If my employment or other affiliation with MH ends, I will immediately return all MH property (keys, documents, equipment, ID badges, etc.). I realize my obligations under this Agreement continue after the end of my employment or other affiliation. I will not share or speak about any information I learned while at MH.
- That I have a responsibility to report any potential privacy or security violations to my supervisor, director, the Corporate Responsibility Department or the Hotline.
- That violating any of the promises or representations made in this Agreement may result in corrective action, up to and including termination and/or suspension, restriction or loss of privileges, as well as potential personal civil and criminal legal penalties.

By my signature below, I certify I have read this Agreement, I have had the opportunity to ask questions, I understand the Agreement and I agree to be bound by its terms.

Caregiver Name PRINT: _____ Date of Birth: _____

Caregiver Signature: _____ Date: _____ Time: _____

Facility Name: _____ Job Title: _____