HIGHLINE MEDICAL CENTER

POLICY / PROCEDURE

Title:	Confidentiality Statement	Policy/Procedure #	[Policy/Procedure #]	Page 1 of 2

Department: Employee Handbook	Effective Date:	[Effective Date]

POLICY

Please check all the appropriate boxes:

- ☐ **Orientation**
- ☐ **Annual Evaluation**
- ☐ **Hospital Employee**
- ☐ **Physician/Intern/Fellow/Resident**
- ☐ **Volunteer**
- ☐ **Contractor**
- ☐ **Other** _____

I _____, *(PLEASE PRINT NAME)* as an employee, physician, student, volunteer or contractor at Highline Medical Center:

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all patient medical records, employee information, financial information, proprietary information, confidential information used in research, and other confidential information arising from or pertaining to Highline Medical Center.
- Agree not to disclose any such information or records to any person outside Highline Medical Center without proper authorization.
- Understand that each time I access protected health information (PHI) I will only use the minimum necessary PHI required to do that function of my job.
- Agree to discuss confidential information only in the work place as appropriate, and only for job related purposes, and to refrain from discussing this information outside of the work place or within the hearing of other people who do not have a need to know about the information.
- Understand that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.
- Understand that any and all references to HIV testing, such as any clinical test, laboratory or otherwise used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected and that unauthorized disclosure may make me subject to legal action and/or disciplinary action.
- Understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal action and/or disciplinary action.
- Understand that my access to all electronic systems is audited regularly, and that any inappropriate access to information may make me subject to legal and/or disciplinary action. Understand that I am not to share my log-in user ID and/or password with anyone, and that any access to Highline Medical Center systems made under my log-in user ID and password is my responsibility.
- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records and the Code of Conduct or any violation of federal regulations governing the patient's right to privacy may result in immediate termination of my employment / professional relationship with Highline Medical Center.

I acknowledge that I have read and understand the above statements.

Signature _____ **Date** _____

Department _____

Citations & References

Related P & P's Procedures	[Related Policy/Procedure 1]	[Related Policy/Procedure 2]	[Related Policy/Procedure 3]	[Related Policy/Procedure 4]	[Related Policy/Procedure 5]
Joint Commission, CMS, Other					

Submitted By:	[Submitted By]
Approved By:	[Approved By]

Review Date/Made By		Revision Description	Revision Date/ Made By	
3/4/2009	am	[Revision Description 1]	9/11/2002	kmb
10/28/2011	L.B.	[Revision Description 2]	6/3/2005	gmh
2/9/2012	GH/EB	New policy	2/9/2012	[Revisor 3]
[Reviewed Date 4]	[Reviewer 4]	[Revision Description 4]	[Revised Date 4]	[Revisor 4]
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