Confidentiality and Information Access / Usage Agreement Form

Security and confidentiality is a matter of concern for all persons who have access to Nuvance Health's information systems. Each person accessing Nuvance Health's data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access data and resources, both through organizational information systems and through individual department local-area networks and databases, must read and comply with Nuvance Health's policy.

I hereby certify and agree that I will:

1. Understand that all access to systems (including network, applications, card swipe and phone) IS ELECTRONICALLY MONITORED.
2. Respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for the performance of my job.
3. Respect the ownership of proprietary software. For example, not make unauthorized copies of software for personal use, even when the software is not physically protected against copying. I will not operate any non-licensed software on any computer provided by Nuvance Health.
4. Prevent unauthorized use of any information in files maintained, stored or processed by Nuvance Health.
5. Not seek personal benefit or permit others to benefit personally by any confidential information or use of equipment available through my work assignment.
6. Not exhibit or divulge the contents of any record or report except to fulfill a work assignment and in accordance Nuvance Health's policy.
7. Not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
8. Not remove any record (or copy) or report from the office where it is kept except in the performance of my duties.
9. Report any violation of this code.
10. Not release user identification code or password to anyone, or allow anyone to access or alter information under my identity, nor will I release my badge or other device to anyone.
11. Not utilize anyone else's access code or card in order to access any Nuvance Health's system.
12. Respect the confidentiality of any reports printed from any information system containing patient/member information and handle, store and dispose of these reports appropriately.
13. Understand that information provided to the news media regarding the condition, care, or treatment of a patient will be given solely by the Department of Public Affairs.
14. Understand that in combination with my PIN, this will be my electronic signature for all medication transactions in the MedSelect system. It will be used to track all of my transactions with a date and time stamp. These records will be maintained as per Hospital and State Drug Control policy and will be available for inspection by the Drug Enforcement Administration (DEA) and the CT Department of Consumer Protection, Drug Control Division.
15. Understand that I may have access to confidential information that may include, but is not limited to, information relating to:
    - Patients/members (such as records, conversations, admittance information, patient/member financial information, etc),
    - Employees/volunteer/students (such as salaries, employment records, disciplinary actions, etc.),
    - Nuvance Health's information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.) and
    - Third party information (such as computer programs, client and vendor proprietary information source code, proprietary technology, etc.).
16. Use confidential information only as needed to perform my legitimate duties as an employee/volunteer/student/contractor affiliated with Nuvance Healths network. This means, among other things, that:
    - I will only access confidential information for which I have a need to know and I am authorized to know. No attempt will be made to inappropriately access unauthorized information concerning family members, friends, coworkers or other parties not related to my job responsibilities; and

- I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of my professional activities affiliated with Nuvance Health's network and
- I will not misuse confidential information or carelessly care for confidential information.

17. Accept responsibility for all activities undertaken using my access code and other authorization.
18. Use discretion when discussing patient information to ensure that conversation is not overheard by those who should not have access to that information.
19. Report activities by any individual or entity that I suspect may compromise the confidentiality of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
20. Understand that an employee has the right to challenge anyone requesting access to confidential information (including a patient's medical record) in order to be assured that the person has the right to view such information.
21. Understand that my obligations under this Agreement will continue after termination of my employment. I understand that my privileges hereunder are subject to periodic review, revision and if appropriate, renewal.
22. Understand that I have no right or ownership interest in any confidential information referred to in this Agreement. Nuvance Health's Network may at any time revoke my access code, other authorization, or access to confidential information. At all times I will safeguard and retain the confidentiality of all confidential information.
23. Be responsible for my misuse or wrongful disclosure of confidential information and for my failure to safeguard my access code or other authorization access to confidential information. I understand that my failure to comply with this Agreement may also result in the denial of access to the relevant computer systems and networks, disciplinary action, up to and including loss of employment at Nuvance Health, loss of privileges, imposition of criminal / civil sanction, and/or notification to licensure authority.
24. Not use my name as my password.
25. Understand that my electronic signature is intended to be the legally binding equivalent of my traditional handwritten signature.
26. Immediately notify the appropriate party in the event that I become aware of lost, stolen or otherwise compromised password information or electronically signed documents.

I understand and agree to all of the terms set forth in this Agreement.

Volunteer Signature	Printed Name
Date	

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