Shasta Regional Medical Center

OFFICE STAFF SECURITY/CONFIDENTIALITY AGREEMENT

Shasta Regional Medical Center uses on-line information systems attached to a network of hospitals, clinics, end-Users, and other facilities to manage business operations and healthcare information. Shasta Regional Medical Center has a duty to protect the confidentiality, integrity, and availability of medical and business information as indicated or required by best business practices, accepted information security standards, laws, professional ethics, and accreditation requirements. Users of Shasta Regional Medical Center computing assets or facilities should not assume their actions are private, privileged or protected. Shasta Regional Medical Center reserves the right to monitor Users in any manner the company deems appropriate.

Confidentiality Policy

I understand and agree that in the course of my business with SHASTA REGIONAL MEDICAL CENTER, any patient identification, medical or personal information learned by me about any person who is a patient, medical or personal information learned by me about any physician or employee, is privileged information and subject at all State and Federal Laws which protect the rights of patients, employees, and/or physicians.

I understand that information learned by me about any patient, employee and/or physician will not be discussed with anyone except personnel authorized by SHASTA REGIONAL MEDICAL CENTER for legally acceptable purposes. Law protects the privacy of our patients, employees, and/or physicians and their rights to be treated with total confidentiality.

The re-disclosure of any medical or personal information is a breach of confidentiality and will be subject to State and Federal regulation and law that includes fines or imprisonment.

Information Security Agreement

Computerized information systems are among the Hospital's most valuable assets. Our success and the privacy of our patients depend on the protection of this information against theft, destruction, or disclosure to outside interests.

I agree to the following provisions:

- To maintain assigned password(s) that allows access to computer systems and equipment in strictest confidence and not discloses password(s) with anyone, at any time, for any reason.
- To access only computer systems, equipment, and function as required for the performance of my responsibilities.
- To contact Information Services (IS) Department immediately and request a new password(s) if mine is (are) accidentally revealed.
- Not to record passwords in any manner, as this increases that possibility of accidental disclosure.
- Not to disclose any portion of the Hospital's computerized system with any unauthorized individual(s). This includes, but is not limited to, the design, programming techniques, flow charts, source codes, screens, and documentation created by Hospital employees or outside sources.

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- Not to disclose any portion of a patient's record except to a recipient designated by the patient or to a recipient authorized by the hospital who has a need-to-know in order to provide for the continuing care of the patient or to discharge one's employment or other service obligation.
- To report activity that is contrary to the provisions of this Agreement to Information Services (IS) Department.

I understand that failure to comply with the above policies will result in the termination of access.

I will refer all requests for release of hospital patient information to SRMC Health Information Management Department.

OFFICE STAFF NAME (PLEASE PRINT):		
PHYSICIAN NAME (PLEASE PRINT):		
EMPLOYEE IDENTIFICATION:	DOB: MONTH - DAY - (NO YEAR)	LAST 4 SSN:
OFFICE POSITION:	DEPARTMENT:	PHONE #:
PRACTICE NAME:		
REASON FOR NEEDING ACCESS:		

OFFICE STAFF SIGNATURE:_____**DATE:** _____
(Needed if requesting office staff access with Physician Approval)

PHYSICIAN SIGNATURE:_____**DATE:** _____
(Stamped signature is not acceptable)

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****** FOR HOSPITAL USE ONLY******	
MEDICAL STAFF DIRECTOR/DESIGNEE:	DATE:
PRIVACY OFFICER/DESIGNEE:	DATE:
INFORMATION SECURITY OFFICER/DESIGNEE:	DATE:
SYSTEM(S) REQUIRED: ☐ WINDOWS ☐ ONE CONTENT ☐ MEDITECH ☐ PACS ☐ EPIPHANY *(EKG)*	
This is for remote access to medical records at the noted provider's office. Please include remote access instruction to the office manager.	