CONFIDENTIALITY AND DATA SECURITY AGREEMENT

I understand that Broward Health has a legal and ethical responsibility to safeguard the privacy of all patients. Additionally, Broward Health must ensure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information (collectively with patient identifiable health information, "Confidential Information"). As an employee, student, volunteer, medical staff member, contractor, or other individual who performs services on behalf of Broward Health or one of its entities, I understand that I must sign and comply with this Agreement to obtain authorization for access to Confidential Information. By undersigning below, I agree to the following conditions:

The following statements apply to all individuals having authorized access to Broward Health systems.

1. My username and password are the equivalent of my signature.
2. I am the only person authorized to use my username and password. I will not disclose my password to anyone or allow others to use my username.
3. I will choose a password which I can remember and that is difficult for others to guess.
4. I will not write my password where another individual may find it.
5. I will log out or secure my workstation whenever I leave the workstation unattended.
6. I will not use a workstation which has been logged onto by another user unless I log them out.
7. I will not attempt to learn another person's username/password and I will not attempt to access information using a username other than my own.
8. All information gained by my password will be treated as confidential and never be released to any person unless I have been authorized to release that information.
9. I understand that I will be held responsible for all actions which I allow to occur under my username or which occur due to my negligence.
10. I will only access and use Confidential Information when it is necessary to perform my job responsibilities in accordance with Broward Health's Privacy and Security Policies.
11. I understand that Broward Health maintains audit trails of access to information and system activity and that the audit trail may be reviewed at any time.
12. I understand the policy governing the use of the Internet and will comply with this policy at all times.
13. I will use all information gained through the computer system for the benefit of Broward Health and its patients.
14. I understand the need to protect Broward Health information both during my relationship with Broward Health and after termination of my relationship. I will protect the confidentiality of all information that I use, originate, discover, or develop in the performance of my duties at Broward Health.
15. I will not electronically copy or transmit Confidential Information not directly related to my authorized duties without specific written authorization from an authorized source.
16. I will participate in all future compliance, privacy, and security training requirements required of my position.
17. I will report any and all suspected privacy and security breaches in accordance with Broward Health's HIPAA privacy and security breach reporting process.
18. I understand that violation of this agreement may result in corrective action, up to and including immediate termination and/or legal prosecution and notification of law enforcement officials and/or state accreditation and licensure boards.

Additionally, the following statements apply to all physicians using Broward Health systems containing patient identifiable health information.

19. I understand that by accessing a patient's record, I am affirmatively representing to Broward Health at the time of each access that I have a requisite business need to know and that Broward Health may rely on that representation in granting such access to me.
20. I will ensure that only appropriate personnel in my office will access Broward Health systems and Confidential Information as authorized by me and in accordance with Broward Health policies and procedures. I will ensure that such personnel receive annual training on issues related to patient confidentiality and access.
21. I will accept full responsibility for the actions of my employees who are granted access to Broward health systems and Confidential Information.

Please complete as applicable.

_____ Full Name (please print)

_____ Signature

_____/____/_____ Date

_____ Employee/Physician Number

Graduate Medical Education Department

127750 Accounting Unit

Region (*check all that apply*): ☒ BHMC ☐ BHHQ ☐ CSMC ☐ IPMC ☐ NBMC

☐ CHS/Physician Practice (*specify site*): _____

Relationship to Broward Health: ☐ Employee ☒ Student ☐ Volunteer ☐ Medical Staff

☐ Contractor (*specify employer*): _____

☐ Other (*specify*): _____

Copy Distribution: White—Human Resources/Medical Staff/Contract Admin/Volunteer Office (as appropriate) Yellow—Individual Signing the Form