

Wellmont Health System
Confidentiality Agreement

It is the policy of Wellmont Health System to maintain the confidentiality of all patient and employee information and certain business information. Wellmont has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information.

In the course of my employment/assignment within Wellmont Health System, I may have access to and be involved in the processing of confidential patient information. I agree that I will not access information on patients for whom I have no responsibilities, nor access patient or other information unless I have a “need to know” the information to perform my specific job duties. I understand that such information must be maintained in the strictest confidence both at work and outside of work. As a condition of my employment/assignment, I hereby agree that, unless directed by my leader or his/her designee, I will not at any time during or after my employment/assignment with Wellmont, disclose any confidential information to any person whatsoever or permit any person whatsoever to examine or make copies of any confidential reports, records, or documents prepared by me, coming into my possession, or under my control, or use confidential information other than as necessary in the course of my employment/assignment. I understand that sharing such information except in the direct performance of my job duties is a violation of trust placed in me as a healthcare professional that jeopardizes the mission and survival of our organization.

I understand that, as a user of Wellmont’s information systems, my user identification code and my password is the legal equivalent of my signature. I am accountable for all transactions performed using this code and/or password and agree to not disclose this code or password to anyone or to attempt to learn or use another person’s code or password. If I have reason to believe that my identification code is known, lost or stolen, I will immediately contact the I.S. Department to have my code “reset”. I understand that the system may be monitored and audits and periodic checks will be performed to confirm my involvement with patients whom I have accessed.

I understand that any violation of this agreement may result in loss of computer system access, legal, and/or other corrective action up to and including termination.

Signature
(Employee, student, volunteer, Contractor, etc.)

Initials

Print Name

Witness

Date