



## Confidentiality and Security Agreement

Shands HealthCare (SHANDS) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their personal health information. Additionally, SHANDS must protect the confidentiality of organizational information that may include, but is not limited to, human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information from any source or in any form including, without limitation, paper, magnetic or optical media, conversations, and film. For the purpose of this Agreement, all such information is referred to as "Confidential and Protected Information." In the course of my employment / association / affiliation with SHANDS, I understand that I may have access and / or exposure to Confidential and Protected Information.

I UNDERSTAND AND HEREBY AGREE THAT:

1. I will access and / or use SHANDS Confidential and Protected Information only as necessary to perform my job-related duties and in accordance with SHANDS' policies and procedures.
2. My User-ID and password are confidential, and in certain circumstances may be equivalent to my **LEGAL SIGNATURE** and I will not disclose them to anyone. I understand that I am responsible and accountable for all entries made and all information accessed under my User-ID.
3. I will disclose Confidential and Protected information only to authorized individuals with a need to know that information in connection with the performance of their job function or professional duties.
4. I will not copy, release, sell, loan, alter, or destroy any Confidential and Protected Information except as properly authorized by law or SHANDS policy.
5. I will not discuss Confidential and Protected Information so that it can be overheard by unauthorized persons. It is not acceptable to discuss information that can identify a patient in a public area even if the patient's name is not used.
6. I will only access and / or use systems or devices I am authorized to access / use, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
7. I have no expectation of privacy when using SHANDS information systems. SHANDS has the right to log, access, review, and otherwise use information stored on or passing through its systems, including e-mail.
8. I will never connect to unauthorized networks through SHANDS systems or devices.
9. I will practice good workstation security measures such as never leaving a terminal unattended while logged in to an application, locking up diskettes when not in use, using screen savers with activated passwords appropriately, and positioning screens away from public view.
10. I will practice secure electronic communications by transmitting Confidential and Protected Information in accordance with approved SHANDS security standards.
11. I will:
  - a. Use only my assigned User-ID and password.
  - b. Use only approved licensed software.
  - c. Use a device with virus protection software.
  - d. Not attempt to learn or use another's User-ID and password.
12. Upon termination of my employment / affiliation / association with SHANDS, I will immediately return or destroy, as appropriate, any Confidential and Protected Information in my possession.
13. Violation of this Agreement may result in disciplinary action, up to and including termination of employment / affiliation / association with SHANDS, suspension and / or loss of medical staff privileges in accordance with the SHANDS policies.
14. Unauthorized or improper use of SHANDS information systems and / or Confidential and Protected Information, is strictly prohibited and may not be covered by SHANDS' insurance or my personal professional malpractice insurance. **Any such violation may subject me to personal liability as well as sanctions for violation of state and federal law.**
15. I will notify my manager, Shands IT Security Officer, or other appropriate Information Services personnel if my password has been seen, disclosed, or otherwise compromised.
16. My obligations under this Agreement will continue after termination of my employment / affiliation / association with SHANDS.

*By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Employee Number \_\_\_\_\_

Entity \_\_\_\_\_  
*(ie, Shands Jacksonville, UF Physicians, College of Medicine, etc.)*

Department \_\_\_\_\_ License # \_\_\_\_\_