STANFORD UNIVERSITY MEDICAL CENTER

Stanford Hospital & Clinics

Lucile Salter Packard Children's Hospital

CONFIDENTIALITY STATEMENT

Please check all the appropriate boxes:

- ❑ Orientation
- ❑ Initial Arrangement

❑ Hospital Employee	❑ Contractor
❑ Physician/Intern/Fellow/Resident	❑ University Employee
❑ Volunteer	❑ Student
❑ Contracted Staff	❑ Researcher
❑ Agency Staff	❑ Other: ___________________

I____, (PLEASE PRINT NAME) as an employee, contracted staff, contractor, physician, intern, resident, fellow, student, researcher, University employee, volunteer, agency staff or other affiliation as set forth above at Stanford Hospital and Clinics (SHC) and/or Lucile Packard Children's Hospital (LPCH):

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all patient identity, patient information, patient medical records, employee information, financial information, proprietary information, confidential information used in research, and other confidential information arising from or pertaining to SHC and/or LPCH.
- Agree not to disclose any such information or records to any person outside SHC and/or LPCH without proper authorization or to anyone inside SHC and/or LPCH who does not have a need to know for treatment, payment, or healthcare operations purpose. Information accessed and used for research, including outside presentations and publications, require appropriate IRB review and approval as well as a signed HIPAA compliant authorization prior to access, use or disclosure unless such authorization is waived by the IRB.
- Understand that I may only remove confidential information and/or patient information from hospital premises for work related activities that have been approved by my supervisor as long as the information is maintained securely so it is not visible or accessible to anyone who does not have a legal right to that information.
- Understand that each time I access protected health information (PHI) I will only use the minimum necessary PHI required to do that function of my job.
- Understand that I am not to remove confidential data from central servers (to store on my personal hard drive, or any removable device such as a thumb drive) without the permission of my department head and/or IT Security. If I remove such data from professionally managed servers, it is my responsibility.
- Agree to discuss confidential information only in the work place as appropriate, and only for job-related purposes, and will not discuss this information outside of the work place or within the hearing of other people who do not have a need to know about that information.
- Understand that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.
- Understand that any and all references to HIV testing, such as any clinical test, laboratory or otherwise used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected and that unauthorized disclosure may make me subject to legal action and/or disciplinary action.
- Understand that the law especially protects mental health, psychiatric, fertility, certain genetic, and drug/alcohol abuse records, and that unauthorized release of such information may make me subject to legal action and/or disciplinary action.
- Understand that my access to all electronic systems is audited regularly, and that any inappropriate access to information may make me subject to legal and/or disciplinary action.
- Agree that I will not provide computer access to anyone using my user name and password and will process all access requests through the SHC/LPCH HIPAA security procedures. I agree to log-off when I am completed with my tasks to avoid someone else using my log-in access. I am not to share my log-in user ID and/or password with anyone and any access to SHC and/or LPCH systems made under my log-in user ID and password is my responsibility.
- Understand that my password(s) that protect confidential information must comply with industry standard and SHC/LPCH password guidelines, ensuring that length and complexity will make passwords very difficult to guess.
- Understand that I am responsible for protecting PHI or medical information that is sent by me via facsimile and/or electronically such as e-mail and I am responsible for following the applicable policies with respect to the transmission of PHI or medical information and that any inappropriate disclosure of information may make me subject to legal and/or disciplinary action.
- Agree not to take any photographs, video recordings, or any imaging of patients, employees, visitors, or anyone else on SHC and/or LPCH property unless I have obtained the appropriate approvals as set forth in the SHC/LPCH photography policy and the appropriate consent and authorization from the individual who is the subject of the photography, recording, or imaging.
- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records and the Code of Conduct or any violation of federal regulations governing the patient's right to privacy may result in immediate termination of my employment / professional relationship with SHC and/or LPCH.

I acknowledge that I have read and understand the above statements will discuss them with my supervisor should I have any questions.

Signature: ____ Date: ________________________________

Printed Name: ____ Department: ____

Revised 03/15/10