

{Insert Practice Name Here}
Healthcare Information User Confidentiality Agreement

I have read and understand the following:

I have been granted access to certain sources of protected health information (PHI) as a requirement of my job duties and I am aware of the following:

- 1) Massachusetts State law and the Federal HIPAA guidelines govern appropriate use of PHI and the sources of PHI may include electronic medical records, databases as well as paper records.
- 2) All system passwords I have been given are unique to me. To assure the privacy rights of patients my user account will be audited for appropriate use by the Practice and the eHealth Central Network Organization (CNO).
- 3) The general guidelines for appropriate access state that PHI may be accessed for specific clinical and financial reasons associated with providing care for the patient.
- 4) There are specific guidelines for disclosure of 'private' classes of PHI in the State of Massachusetts, which are different than the Federal HIPAA guidelines.
- 5) There are also specific State and Federal guidelines for the release and disclosure of PHI that protect against unauthorized release of information.

I agree to the following stipulations regarding the access and use of sources of PHI, as related to my position:

- 1) I will access PHI only for purposes of performing my specific job duties. I will limit my access to PHI to only that which is necessary for performance of my specific job duties as they relate to providing effective medical care for patients or for producing financial bills for services rendered.
- 2) I will keep my system passwords private and I understand that my passwords are unique to me and any activity logged, which is associated with my password, is my responsibility.
- 3) I understand that information obtained via my password falls under the definition of 'Protected Health Information' (PHI) and is subject to the State and Federal (42 CFR, PART 2) laws governing access and disclosure rights of patients.
- 4) I understand that the Federal and State privacy & security laws prohibit me from making any further disclosures of PHI, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by Federal (42 CFR, PART 2) and State regulations.
- 5) I understand that there are certain classes of PHI which fall under separate guidelines and that a general patient consent will not necessarily apply to these classes of information. I understand that per-occurrence consent to disclose may be required for these special classes.
- 6) I understand that all patient data accessed via my privileges should be treated as highly confidential and that copies of records in any form (paper or electronic) are the property of the Practice and they are protected from disclosure to the patient or any third party. I am therefore required to follow the Practice release of information policy.
- 7) I understand that electronic systems contain certain security rights, rules, levels of access and information disclosure features. I furthermore understand that these features do not preclude my understanding and following of all State and Federal laws regarding use and disclosure of PHI.

Signed: _____, Date: _____

Please Print Name: _____, Practice: _____