OhioHealth Grant Medical Center

CONFIDENTIALITY STATEMENT OF UNDERSTANDING
(to be signed by employees and students)

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information belonging to the OhioHealth member hospitals, as set out in the Hospital SPP "Security and Confidentiality Policies & Procedures." It is the responsibility of all persons granted access to confidential information to protect the confidentiality of patient and hospital information and to make use of that information only to the extent authorized and necessary to provide patient care and/or to perform a proper Hospital, Medical Staff or educational function.

"I _____(Name) recognize and acknowledge that all patient-identifiable information and certain of the information the OhioHealth hospitals and Ambulatory Sites maintain for business purposes is confidential. By reason of my duties, I may come into possession of the confidential information even though I may not take any direct part in furnishing the patient services or developing the business information.

I agree that I will not, at any time during or after my employment or term of service, improperly disclose any confidential information to any person or permit any unauthorized person to examine or make copies of any reports, documents, or on-line information that comes into my possession. Additionally, as this confidential information is available only on a need-to-know basis, I will not access confidential information without authorization and will do so only when required to do so.

I recognize that the unauthorized disclosure of confidential information is completely prohibited.

I also recognize that the disclosure of or sharing of passwords, access codes, and key cards, assigned to me is prohibited and that I am accountable for them for any improper access to information gained with these privileges. My access privileges are the equivalent of my legal signature and I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using those privileges. If I have reason to believe that the confidentiality of my access privileges has been broken, I shall immediately notify my manager or the Director of Information Services at my facility.

I understand that if I violate any of the above statements I amy lose my access privileges immediately and that any violation may result in corrective action from my employer, sponsoring organization or academic institution in the interest of the patient and Hospital."

Full Name (Print)	**Check Box & Specify Location**
Signature:	Grant Campus: X
Date:	School: **EMS EDUCATION**