University of Tennessee Health Science Center

Confidentiality Agreement

Each faculty member, staff member, other employee, and student of the University of Tennessee Health Science Center who is afforded access to confidential, protected health information in medical or dental records, billing records, research records or in other forms which is considered individually identifiable, agrees to abide by the following terms:

1. Patient care information, whether written, oral, or in electronic computer system form is confidential and may be accessed only by employees or authorized contracted personnel who need that information to perform their job or contractual responsibilities. Only authorized personnel may release patient care information to individuals outside the health system.
2. I understand that this information belongs to the patient; I am only the caretaker. I must guard the documentation appropriately to prevent conversation being overheard by people without a right to know the information. This includes, but is not limited to the following:
    a. Keeping patient information secure, private, and out of public viewing
    b. Protecting computerized data by logging off when leaving a work station
    c. Keeping information secure by not discussing patient specific issues in public areas such as elevators or anywhere outside the workplace.
3. I agree that personnel may only access information necessary to perform their job responsibilities. I agree not to disclose, communicate, or use any patient information in any manner whatsoever other than within the course of my job responsibilities. Even within those responsibilities, I will limit the dissemination of information to those persons who have a need to know.
4. I agree to dispose of copies of reports and other confidential information by shredding them when the final reports have been proofread and signed. I also agree to safeguard tapes and other recording media on which confidential information has been recorded.
5. I understand that the confidentiality of information survives the termination of my relationship with the University of Tennessee.
6. I understand that if I do not keep this information confidential, or if I allow or participate in the inappropriate dissemination of (or access to) personal patient information, I will be subject to disciplinary action according to the University Code of Conduct and other University policies in addition to facing the possibility of litigation and monetary sanctions.
7. I understand that criminal offenses regarding disclosure of protected patient information will be reported to the proper authorities.
8. I agree to comply with all state and federal laws applicable to the use of confidential patient information including the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the Patient Privacy Protection Act and the Tennessee Medical Record Act, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the Family Educational Rights and privacy Act (FERPA) of 1974.

My signature attests to the fact that I have read, understand and agree to abide by the terms of this statement and to the University of Tennessee's policies on confidentiality of patient care information as well as the policies on confidentiality of payroll, personnel, student, and financial records.

Printed Name_____

Signature_____

Department Name_____

Date_____