Sibley Memorial Hospital
Volunteer Service Department
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SIBLEY MEMORIAL HOSPITAL CONFIDENTIALITY AGREEMENT

A. Patient Information

It is Sibley Memorial Hospital's obligation to respect the rights of patients to Personal Privacy and Confidentiality of "Personal Health Information" in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and applicable District of Columbia Law.

To assist the Hospital in meeting its obligation, I agree not to disclose any information about a patient, received in the course of performing my duties as an Associate at Sibley, to anyone except as required to perform my duties or as otherwise legally required. An Associate is any employee, volunteer, contract worker, consultant or other person who, through proper authorization, has access to computers or confidential information maintained at Sibley.

1. I understand and agree that all patient information is considered confidential and private, including the fact that the patient is in the Hospital.

2. I shall consult with my Supervisor or Department Head in order to make the appropriate decision regarding the communication of any patient information that may be confidential in nature.

3. I will not ask or seek information about patients, their conditions, or any information about their families, without a specific need to know, which is related to my job duties;

4. I will not discuss a patient's hospital stay or any information associated with that stay, with any person outside the Hospital, without the authorization of the patient or the patient's designated representative;

5. I will not discuss the private lives of patients, their families, or another associate, without the authorization of the person being discussed;

6. I will not reveal the nature or content of an individual's personal property removed from the patient in the normal course of admission or care.

7. I agree to report any unauthorized disclosure of a patient's information to Sibley's Compliance Officer or call Sibley's compliance/HIPAA hotline at (202) 243-2260. These calls may be made anonymously.

8. I understand my obligation to maintain the confidentiality of patient information is a continuing one that extends indefinitely, even after termination of my employment or business relationship with Sibley.

9. I understand that disclosure of confidential information without proper authorization may subject me to disciplinary action up to and including termination.

B. Organizational/Proprietary Information

I agree not to disclose any Organizational/Proprietary information that may include, but is not limited to, patient identifiable, financial, employee identifiable, intellectual property, non-pubic, contractual, of a competitive nature, and from any source or in any form (i.e., paper, magnetic, or optical media, conversations, film, etc.) considered confidential. I agree to protect this confidential information as required by law and the strict policies of Sibley Memorial Hospital.

1. I will not access Hospital information from any source except in connection with performance of assigned duties.

2. I will not disclose any confidential information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right or ownership interest in the confidential information.

3. I will limit distribution of confidential information to parties with a legitimate need in performance of the organization's mission.

4. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship.

C.   Computer Access, Confidentiality, Terms and Conditions

As a condition to receiving a computer user code and being allowed access to computer systems, and/or being granted authorization to access any form of confidential information identified above, I agree to comply with the following terms and conditions:

1. I will not access confidential information for which I have no legitimate need to know and for which I am not an authorized user.

2. I will not utilize another user's password in order to access any system nor will I reveal my computer password to anyone else for any reason. I accept personal responsibility and understand that I will be held accountable for all activities occurring under my computer user code.

3. I understand that all information, regardless of the media on which it is stored, the system which processes it, or methods by which it is moved is the property of Sibley Memorial Hospital and shall not be used inappropriately or for personal gain.

4. I understand that Sibley Memorial Hospital reserves the right to inspect or monitor any company owned, leased or controlled computer, computer device, network, computer facility, storage device, voice mail or telephone system at any time for any reason and that SMH may divulge any information found during such inspections or monitoring to any party it deems appropriate.

5. I understand that I should no consider electronic communications to be either private or secure, nor have an expectation of privacy in anything I create, store, send, or receive on the computer and network.

6. I will not leave a secured computer application unattended while signed on.

7. I recognize that Sibley Memorial Hospital licenses the use of its computer software from a variety of companies. The hospital does not own this software or its related documentation and, unless authorized in writing by the software developer, no hospital associates have the right to reproduce or modify the licensed software.

I understand that my failure to comply with this Agreement may result in corrective action, which might include, but is not limited to, termination of employment, business relationship and/or loss of privileges within Sibley Memorial Hospital, as well as potential criminal penalties. By signing this Agreement, I acknowledge the afore-mentioned requirements for access and use of confidential information of Sibley Memorial Hospital and the consequences of inappropriate use or disclosure. I understand my rights and agree to abide by this Confidentiality Agreement:

_____   _____
Applicant signature   *Date*

_____
Applicant name (print)

_____   _____
Parent/Guardian signature (if Applicant is under 18-years-old)   *Date*

_____
Parent/Guardian name (print)