WORKFORCE CONFIDENTIALITY AGREEMENT

Children's Hospital and its affiliates (hereinafter "Organization") have a legal and ethical responsibility to safeguard the privacy of all patients and to protect and safeguard the confidentiality of health information. Additionally, the Organization must assure the confidentiality of its patient, human resources, payroll, fiscal, research, computer systems, computer access, management information, and/or personal computer access codes (hereinafter "Confidential Information").

By signing this document, I agree not to directly or indirectly use or disclose Confidential Information without proper authority and specifically agree with the following:

1. In the course of my employment/assignment/medical privileges/efforts/training at the Organization, I may come into the possession of Confidential Information. I understand that such information must be maintained in the strictest confidence.
2. I agree not to use, disclose or discuss any Confidential Information with others, including friends or family, who are not authorized or who do not have a need-to-know.
3. I agree not to access any Confidential Information, or utilize equipment, unless I have a clinical or business reason to do so.
4. I agree not to discuss Confidential Information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, or at social events. Discretion must be used when discussing Confidential Information in public areas even if a patient's name is not used, since it can raise doubts with patients and visitors about our respect for their privacy.
5. I agree not to make inquiries for other personnel who do not have proper authority or need-to-know.
6. I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
7. I agree not to make any unauthorized transmissions, inquiries, modifications, or deletions of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Organization computer systems to unauthorized locations (e.g. home).
8. I agree to log-off prior to leaving any Organization computer or terminal unattended.

I further acknowledge that a copy of the Organization's Information Privacy and Security Program and related policies are available to me upon request.

I have read and agree to the terms and conditions of this agreement, and understand that any violation may result in corrective action, up to and including termination and/or suspension and loss of privileges.

____ _______________
Signature of Employee / Staff Physician / Student / Researcher Date

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Print Name

Please return this signed document so that it can be filed in your personal record.

Please direct any questions or concerns you have regarding this document or the Organization's Information Privacy and Security Program to the Privacy Officer, 200 Henry Clay Ave., New Orleans, Louisiana 70118 or by phone (504) 894-5395