CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

I , _____understand that as an employee, member of the medical/dental/pharmacy staff, office employee, non-patient care provider or support personnel (volunteer, intern, student, contractor, vendor, etc.) of Anderson Free Clinic (The Clinic), the performance of my job may require me to access or become aware of confidential information, such as:

- Patient health care and financial information - known under HIPAA as Protected Health Information
- Employee personnel information
- Volunteers personal information
- Business information relating to Anderson Free Clinic (including financial, administrative, resource management, and other information)

By signing below, I understand and agree to the following:

a. Approval to access and use the above information in verbal, written, or electronic (stored in computer) form is a privilege. I also understand that access to Anderson Free Clinic information is granted to me based only on business or clinical “need to know” standards and the responsibilities of my job as an employee, member of the medical staff, or non-Anderson Free Clinic patient care provider or support personnel. I agree to access information only on patients for whom I, my office, or service area has responsibility. Patient information may be used for research or teaching purposes only when authorized in writing by Anderson Free Clinic Executive Director.

b. The methods I use to get information may only be used in the performance of my job. I understand that if granted a sign-on code, password, and/or key that I accept full responsibility for any use or actions taken with my sign-on code(s), password(s), keys or Personal Identification Numbers (PIN), and recognize that, in some cases, these codes may be the equivalent of my signature. The codes will be used only by me and I will not use another person's codes at any time. I will notify the AnMed "Help Desk" immediately should my code be compromised in any way or if an issued key is lost or stolen.

c. I may not seek access to any information that is not required to do my job. I understand that an audit trail, noting my code(s) or PINs, the patient, or system accessed and the date may be reviewed by Anderson Free Clinic and AnMed Health. I understand that patient information accessed through the computer is considered the same as the patient's medical record and may not under any circumstances be re-disclosed without proper authorization. I agree to access, use, store and dispose of information which I use in a way that ensures continued security and confidentiality in accordance with HIPAA.

d. In accordance with Anderson Free Clinic Whistleblower Protection Policy I have the responsibility to report violations or suspected violations of this agreement by anyone in a relationship with The Clinic, and that any report may be submitted on a confidential basis. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Violation of this Agreement will result in disciplinary actions, up to and including immediate termination of my relationship with Anderson Free Clinic. In addition, **violation of this Agreement** may result in possible legal action, fines or criminal prosecution against me and the organization I may be representing

Signature: _____ Date: / /

Relationship with Anderson Free Clinic: _____

Security Representative: _____ Date: / /