District Health Department & Home Health Agency

Serving Harrison, Nicholas, Scott & Bourbon County Home Health

LOCAL HEALTH DEPARTMENT EMPLOYEE CONFIDENTIALITY/SECURITY AGREEMENT

This Confidentiality/Security Agreement is established in accordance with the following statutes, and regulations. KRS 194.060; KRS 214.420; KRS 434.840 thru 434.860 Unlawful Access to Computer; Public Law 91.572 and accompanying Regulations; and the Privacy Act of 1974.

I understand all information pertaining to personal facts and circumstances obtained by health department staff shall be confidential. Any information that can be linked to a specific person through the patient's identifying number which is or contains his/her Social Security number, his/her address, or telephone number is deemed confidential. Such information may be in the form of a person's personnel record, medical record, excerpts from the medical record, computer generated reports, computer discs, computer screens, copies of computer screens and conversations which identify the patient. All such information shall be safeguarded against access/use by unauthorized persons, and shall be stored out of sight when not in use.

I understand that patients I see and patient specific information I learn from conversations or observations as a student preceptor of the local health department is confidential. I will not disclose information about specific individuals.

I understand that all USER ID/Passwords to access computer data are issued on an individual basis. I further understand that I am solely responsible for all information obtained, through system access. At no time will I allow use of my user ID/Password by another person except in the case of emergency.

I will ____ or will not____have access to information, records or reports concerning persons provided services for Sexually Transmitted Diseases. I understand that data concerning these patients are not to be shared with anyone who is not assigned to STD activities.

I understand that accessing or releasing confidential information and/or causing confidential information and/or records to be accessed on individuals, clients, relatives, etc. outside the scope of my student practicum experience would constitute a violation of this agreement and could result in disciplinary action taken against me.

I understand that disclosure or intentional release of personal information against an individual's wishes will be reported directly to the University in which I am enrolled as a student. I understand that I may also subject me to civil liability, fines, and/or incarceration and that I will be prosecuted for any violation of these laws for which I am responsible.

I have read this agreement, understand it, and agree to comply with its terms. In addition, it is my responsibility to report violations of this agreement by any employee to my preceptor or human resources department. I acknowledge I have had an opportunity to ask questions and I feel I understand this information. I further agree it is my responsibility to assure the confidentiality of all information which has been issued to me in confidence even after my practicum experience with the health department ceases.

_____ _____

Student Name Date

_____ _____

Appointing Authority Date

June 2017

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