UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

TEAM MEMBER CONFIDENTIALITY AGREEMENT

I understand that, as part of my job, I will learn information about University of Maryland Upper Chesapeake Health's patients, team members, and/or business. I understand that all protected health information and some team member and business information is considered confidential in nature and I have an obligation to protect this information from inappropriate disclosure. In addition, I must comply with the UM UCH Disclosure of Protected Health Information and Minimum Necessary Use or Disclosure of Protected Health Information policies.

THEREFORE, I agree to the following:

- I accept personal responsibility to protect confidential information from inappropriate disclosure without regard to the method by which it was accessed, even if it was obtained inadvertently. I understand that this information may concern, but is not limited to, patients, team members, operations, medical staff and business practices.
- I will not seek protected health information unless I have a need to know the information in order to perform my assigned job functions. If I am unsure of the confidential nature of any information, I will contact my supervisor or the Privacy Officer for clarification.

I will protect the privacy and confidentiality of all UM Upper Chesapeake Health patients during and after my employment/volunteer affiliation. This includes but is not limited to electronic, social media, written, and verbal forms of communication. Protecting the privacy and confidentiality applies to any individual who I come into contact with whether an acquaintance, friend, colleague, neighbor, or relative of mine.

- I understand that Upper Chesapeake Health may routinely monitor and audit access to protected health information for appropriateness of access.
- I will maintain the confidentiality of any unique information system Password/PIN(s) that I may be assigned.
- I will not share my unique Password/PIN(s) with any other person(s).
- I will contact the Privacy Officer immediately if I suspect that knowledge of my unique Password/PIN(s) has been gained by someone else. I understand that the purpose of this notification is to protect confidentiality by having my unique Password/PIN(s) changed.
- I understand that I am responsible for all activity logged under my Password/PIN. I will sign off the computer when I leave the terminal/PC, and I understand that I must log off before another user may use the equipment.
- I understand that any breach of confidentiality may result in irreparable harm to both the patient and UM Upper Chesapeake Health.
- I will use the E-mail system in ways consistent with policy.
- I understand that if I breach confidentiality, UM Upper Chesapeake Health may initiate disciplinary action up to and including immediate termination of employment/volunteer affiliation.

_____	_____	_____
Signature of Team Member	Date	Last 4 Digits of Soc Sec #
_____	_____	
Print or Type Name	Birth Month/Birth Day (MM/DD)	
_____	_____	
Department	Job Code	