

Example Confidentiality Agreement

[Note: This document can be used “as is” or with modifications. Insert your program name and/or Health Department name where indicated. Remove this instruction text on the final version. Before use, have your legal counsel review, make necessary changes and approve the document to ensure it conforms to your local policies.]

[Add Your Department of Public Health Name] HIV/VH/STD/TB USAPI Confidentiality Agreement

I, the undersigned, have read, understand and agree to abide by the [Program Name] Confidentiality and Data Security Policy and [State/Island/Country law] which states that all reports, records, and data pertaining to the treatment, reporting and research associated with serious communicable diseases including HIV/VH/STD/TB are confidential.

Furthermore, I understand that violation of these standards is subject to appropriate disciplinary action(s) on the part of [Your Health Department Name], that could include being discharged from my position and/or being subject to other penalties. By initialing the following statements, I further agree that:

Initial Below

_____ I will only release surveillance and surveillance-related information, reports, or records, in accordance with established data release policies.

_____ I have reviewed and am aware of all policies regarding the handling of paper and/or electronic patient records both onsite and offsite and will treat this information securely and confidentially according to established policies.

_____ Any document to be disposed of that contains patient identifiers shall be shredded when no longer needed.

_____ All confidential files, including electronic files, will be kept in a secured fashion per policy.

_____ Any confidential files that I am working with will be locked up when I leave my workstation unattended.

_____ I will not receive visitors at any secure workstation when confidential information is out or visible.

_____ I will conduct telephone conversations and/or conference calls, requiring the discussion of identifiers, only in my secure work area or other confidential areas.

_____ When working on network files on my computer, I will log off when finished to prevent access to confidential files and databases.

- _____ I will ensure that my network and workstation accounts or work related components have passwords that contain a mix of alpha/numeric characters at a minimum.
- _____ I will not disclose/give my computer password or office keys to unauthorized persons.
- _____ Data generated and used while employed remains the property of **[Your Health Department Name]** and not the individual employee.
- _____ I will not discuss any identifying information except in the performance of job-related duties, being especially mindful that these discussions do not occur in hallways, elevators, lavatories, lunch rooms or other public areas.
- _____ Knowledge of someone's medical status obtained in either a work or social setting during or after one's work with the program is to be treated confidentially, i.e., not shared with persons outside of the program or with co-workers unless they have the need to know because of their surveillance responsibilities.
- _____ Infringement of these rules will be documented and placed in my personnel file.
- _____ Upon leaving employment with the **[Your Program Name]**, I will return all items in compliance with elements on the resignation check list.
- _____ The screensaver on my desk/lap top computer has been set with a password. The screensaver is set to come on every 10 minutes or less.
- _____ I have received security and confidentiality training as required by the department, have read and understand the **[Your Health Department Name]** information technology and security policies, and I agree to be bound by their provisions. **[As applicable to Information Technology Staff]**

For Students/Interns/Third Parties

In addition to initialing above, please initial below:

- _____ As a student/intern/third party within the **[Your Program Name]**, I recognize that I will be privy to confidential information.
- _____ I understand the importance of assuring confidentiality as required by the section rules and policies, state law, and other federal requirements.
- _____ The time spent with the **[Your Health Department]** will be used to the benefit of the department and the people of **[Your State/Island/Country]**. My interest in this appointment/internship is to gain valuable exposure to public health matters.

Employee/Student/Intern/Third Party:

PRINT NAME

Signature

Date

I hereby certify that I have provided the above employee with a copy of the **[Your Health Department]** Policy regarding HIV/VH/STD/TB Surveillance and Program Data Security and Confidentiality training materials.

Supervisor's Signature

Date