Non-Employee Confidentiality and Non-Disclosure Agreement

Please fax completed form to (574) 647-3062 or email to ISSecurity@beaconhealthsystem.org

(Please print)

First Name: _____

Middle Initial: _____

Last Name: _____

Last 4 Digits of SSN: ☐☐☐☐

DOB: ☐☐/☐☐/☐☐☐☐ (M M / D D / Y Y Y Y)

BHS Department _____ Dept # _____

School/Organization Affiliation _____

Job Title _____

Email _____

Phone # ( ) -

Security and **confidentiality** are matters of concern for all persons who have access to information **from Beacon Health System (Beacon).** Each person accessing any Beacon information, **including, but not limited to, patient, provider, administrative, employee and financial information**, holds a position of **trust** relative to this information and must recognize the **responsibilities** entrusted in preserving the **security** and **confidentiality** of this information.

As a condition to receiving access to information, I, _____, agree to comply with the following terms:
(print name)

1. I will not at any time **during or after** my affiliation with Beacon disclose patient, business, financial, or employee information to which I have access **in any form** (i.e. electronic media, paper, microfilm, verbal, etc.) without prior written consent of Beacon or unless required by law.

2. I will not **access or request information** on myself, patients (Protected Health Information), or any other confidential information including Beacon's financial or personnel information, unless the access to this information is required by my job.

3. My computer login is equivalent to my **LEGAL SIGNATURE,** and I will not **share or disclose** my login information, **including user names or passwords,** to anyone. In addition, I will not attempt to use another person's login and password. I am **responsible and accountable** for all entries made and all information accessed under my login.

4. If I have reason to believe that another person knows my computer login, I will **immediately** follow the approved procedure for changing my password. I will also immediately notify the Information Security Team at InformationSecurity@beaconhealthsystem.org and/or my manager.

5. I will secure the computer when not in use to prevent unauthorized access.

6. I will respect the confidentiality of any reports and handle, store, and dispose of these reports according to Beacon policies and procedures. I will also respect the confidentiality of information stored on the computer, including any portable computers or devices I may work with.

I acknowledge my responsibility as an affiliate of Beacon. I understand there are disciplinary procedures in place for handling breach of confidentiality. I have read and understand the above Confidentiality and Non-Disclosure Agreement. I understand that my use of Beacon information will be monitored to ensure compliance with this agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action, including civil or criminal action being taken against me, loss of privileges to access information, termination of contract or any other legal remedy available to Beacon. I accept my obligation to maintain the confidentiality of patient and provider information and agree to abide by the terms of the Agreement.

Signature: _____ Date: _____

Original – Information Systems Department