McLean County Health Department
Workforce Confidentiality Agreement

I understand the McLean County Health Department (hereinafter referred to as the "Department") has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality and safeguard the privacy and security of identifiable Protected Health Information (PHI) and other client and Department information.

As a member of the Department's workforce*, I understand that I may see, hear or otherwise come into contac with PHI, and other confidential client information, such as financial and service data that I am obligated to maintain as confidential. (*Workforce includes full-time and part-time employees; volunteers, including the MCHD Medical Reserve Corps; appointees; students; interns; externs; and, other individuals engaged by or otherwise responsible to the Department, who are involved directly or indirectly in performing the Department's responsibilities.) To be a member of this Department's workforce, I understand I must sign and comply with this agreement. By signing this document, I understand and agree to the following:

I will only disclose Protected Health Information, client and/or other confidential information if such disclosure complies with the policies of the Department, and is required for the performance of my responsibilities.

I will keep my personal access code(s), user ID(s), access key(s) and passwords(s) used to access computer systems and/or other equipment confidential and secure at all times.

I will not access or view any information other than what is required to perform my responsibilities. If I have any question about whether access to certain information is required, I will immediately ask my supervisor for clarification.

I will not discuss any PHI and/or other information pertaining to clients in an area where unauthorized individuals may hear such information (i.e., in hallways, on elevators, in the lunch room, on public transportation, at restaurants, at social events). I understand it is not acceptable to discuss any such information in public areas even if specifics such as a client's name are not used.

I will not share any PHI and/or other information pertaining to clients on social media sites or in personal communications (i.e., texts; email; mobile phone or other electronic devices).

I will not answer inquiries about any PHI from any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purge any PHI, client and/or confidential information from Department records or systems. Such unauthorized transmissions include, but are not limited to, removing and/or transporting such information from the Department's computer system or paper filing system to unauthorized locations (i.e., home, community-based organizations).

I understand any PHI that I view does not belong to me.

I agree that under terms of this agreement, after leaving the Department's workforce, my legal and ethical obligations regarding protection and confidentiality of PHI will not end.

I understand any violation of this Agreement may result in disciplinary action, up to and including termination o my responsibilities with the Department; and/or potential personal, civil and criminal legal penalties.

I have read the above and agree to comply with all its terms and conditions.

______________________________________ ____________________
Signature of Workforce Member (MRC) Date

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Print Name