WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER®
SAN ANTONIO

Confidentiality/Security Acknowledgement

The UT Health Science Center at San Antonio (Health Science Center) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. During your employment or affiliation with the Health Science Center you may hear or read information related to a patient's health or see computer or paper files containing confidential health information, whether or not you are directly involved in providing patient services. You may also create documents containing confidential patient information, if it is part of your job description and/or as directed to do so by your supervisor.

As part of your employment or affiliation with the Health Science Center, you agree to adhere to the following regarding confidentiality and security of patient information:

- ✓ *Confidential Health Information.* I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient's health, must be maintained in the strictest confidence. Except as permitted by this Acknowledgement, I will not at any time during or after my employment or affiliation speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, except as allowed within my job duties or by patient authorization.

- ✓ *Permitted Use of Patient Information.* I understand that I may use and disclose confidential patient information only to other providers of health care services, if the purpose of the disclosure is for treatment, consultation, or referral of the patient. If my job description allows, I may also disclose information for payment and billing purposes and/or internal operations, such as use for internal quality studies and for internal education activities.

- ✓ *Prohibited Use and Disclosure.* I understand that I must not access, use or disclose any patient information for any purpose other than stated in this Acknowledgement. I may not release patient records to outside parties except with the written authorization of the patient, the patient's representative, or for other limited or emergency circumstances. Special protections apply to mental health records, records of drug and alcohol treatment, and HIV related information. I must neither physically remove records containing patient information from the provider's office, clinic, or facility, nor alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to health information without a legitimate, work-related reason.

I also agree to immediately report to my supervisor or to the Health Science Center Privacy Officer in the Office of Regulatory Affairs & Compliance any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of confidential patient information that I see or know of others making that may be a wrongful disclosure.

- ✓ *Safeguards.* In the course of my employment or affiliation if I must discuss patient information with other health care practitioners in the course of my employment or affiliation, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations. I understand that when confidential patient information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this Acknowledgement.

  Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format, oral/verbal, fax, written, or electronic/computer.

- ✓ *Electronic Device Security.* If I keep any identifiable patient information on a state-owned laptop or other electronic device, I agree to encrypt and/or password protect information on electronic devices. I agree not to download identifiable patient information onto personally owned electronic devices. I agree to "secure" e-mail (++ in subject line) when sending patient information outside the uthscsa.edu domain. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone, or allow anyone to access or alter information under my identity. I will back-up any confidential information using approved back-up procedures.

- ✓ *Social Media Use*. I agree to never store patient health information on social networking Web sites or transmit through peer-to-peer applications.

- ✓ *Physical Security.* I will take all reasonable precautions to safeguard *confidential* information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, encrypted laptops and electronic devices, etc. I agree to store my electronic media on approved institutional servers and store back-up media in approved locations.

- ✓ *Return or Destruction of Information.* If my employment or affiliation with UT Health Science Center requires that I take patient information off the Health Science Center campus or off the property of the Health Science Center affiliates, I will ensure that I have the Health Science Center's or the other facility's permission to do so. I will protect patient information from unauthorized

disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

- ✓ *Termination.* When I leave my employment or affiliation or complete my training or residency at the Health Science Center, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the Health Science Center or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.

- ✓ *Violations.* I understand that violation of this Acknowledgement may result in corrective action, up to and including termination of my employment or affiliation. In addition, violation of privacy or security regulations could also result in fines or jail time.

- ✓ *Disclosures Required by Law.* I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if the Health Science Center is complying with federal or state privacy laws.

  I understand that nothing in this Acknowledgement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

My signature, on the following page, acknowledges that I have read the terms and conditions of this Acknowledgement. The signature page will be maintained by my department supervisor.

NOTE: To access specific policies regarding privacy or security issues, please refer to the *Handbook of Operating Procedures* (HOP), available at http://www.uthscsa.edu/hop2000/. Security policies are located in Chapter 5 and privacy policies in Chapter 11.

Confidentiality/Security Acknowledgement
Signature Page

By my signature below, I acknowledge that I have read the terms and conditions of the Confidentiality/Security Acknowledgement.

Signature: ____

Please circle *Employee* *Student* *Resident/Intern* *Non-employee*

Printed name: ____

Date: ____

Work Phone: ____

Department: ____