Affirmation Statement

on Security and Privacy of Information

My signature below verifies that I have read and commit to the Huntsville Hospital requirements for confidentiality of protected health information (PHI). Additionally, I am aware of and will follow hospital policies regarding the Privacy and Security of PHI including the use, disclosure, storage and destruction of PHI. I will only access patient information that I need to do my job at the Hospital. I will not access (via I-Care, WellSoft, Mckesson, etc) patient information of family members (i.e. children, spouse, etc), co-workers, or other people that is not required to perform my job.

Confidential Information includes PHI as well as information concerning quality assurance functions, contracts, business arrangements, employee information and propriety information relating to the hospital's finances, operations or future plans as described in Administrative Policy "Confidentiality."

As part of the terms and conditions of my employment or association, I hereby agree and accept that I will not, during my employment (or affiliation) or after it ends, access PHI, or disclose confidential information except as required for my job duties and in accordance with all policies and laws governing disclosure or Release of Information.

I agree that user identification codes and passwords will not be shared. Neither will I make an attempt to learn or use another employee's or associate's passwords. I am responsible for the use and protection of my unique computer log-ins (passwords).

If I am an instructor, I understand that I assume responsibility for the actions of the students under my supervision to comply with the Security and Privacy of Information Policy.

If I am a physician, I understand that I assume responsibility for the actions of my employees or office staff to comply with the Security and Privacy of Information Policy.

Training: Members of the hospital workforce receive training on security and privacy during New Employee Orientation and during annual required training. Any updates or changes to policies will be communicated via staff meetings, intranet and/or mandatory requirements tests. Annual Renewal: I acknowledge that I know where to find policies for Privacy, Confidentiality and Compliance.

Corporate Compliance: It is my responsibility to follow policies and regulations as well as State and Federal laws. I understand that I am responsible for knowing the rules and policies that apply to my job. The hospital has a Corporate Compliance program to assist my knowledge of the rules. The hospital also monitors compliance with Federal and State laws and regulations, which includes my use of hospital equipment and information systems. I am not aware of any violations of policies, laws or regulations and agree to report any violations to the Corporate Compliance Officer. Questions about whether actions taken by the hospital are legal should be referred immediately to the appropriate supervisor, or to the Corporate Compliance Officer.

Computer Applications: I further understand that I may be provided access to certain hardware and software applications, some of which may be proprietary to their respective vendors. I agree to keep the hardware and software applications confidential, to not disclose to third parties, and to use such hardware and software applications only for the benefit of Huntsville Hospital.

Exclusion List or Status: I confirm that I have not been excluded by the U.S. Government from participating in any governmental program nor, to the best of my knowledge am I under investigation. I agree to notify the Corporate Compliance Officer immediately upon my receiving written or verbal notification that I am proposed for exclusion from any governmental health program.

I understand that a violation of this affirmation statement could result in disciplinary action up to and including termination of employment/contract/ association/appointment and a report to my professional regulatory body. Additionally, federal law provides for the imposition of fines and imprisonment pursuant to HIPAA violations.

PRINT NAME: _____ ID # _____

AFFILIATION: □ Employee □ Volunteer □ Physician □ Contractor □ Instructor/Student □ Other _____

SIGNATURE: X_____DATE: _____

WITNESS SIGNATURE: X_____DATE:_____

04/02, 12/04, 08/07, 04/08, 02/12, 5/15Form # NS 286320