TRINITY HEALTH
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT

The following rules for Confidentiality and Network Access apply to all non-public patient and business information (Confidential Information) of Saint Alphonsus Health System (SAHS), Trinity Health, and related organizations. The rules also apply to the non-public and business information of joint ventures, or of other entities and persons collaborating with Saint Alphonsus Health System and Trinity Health, to which the user has access. As a condition of being permitted to have access to Confidential Information relevant to my job function or role I agree to the following rules:

1. **Permitted and required access, use and disclosure:**
    - I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other health care operations functions permitted by HIPAA and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.
    - I will access, use or disclose Confidential Business Information only for legitimate business purposes of Saint Alphonsus Health System or Trinity Health.
    - I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including:
        - Making sure that paper records are not left unattended in areas where unauthorized people may view them;
        - Using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential information from my workstation or other device;
        - Appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded;
        - Safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smart phones, PDAs, CDs, and USB thumb drives.
    - I will disclose Confidential Information only to individuals, who have a need to know to fulfill their job responsibilities and business obligations.
    - I will comply with Saint Alphonsus Health System /Trinity Health's access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.
2. **Prohibited access, use and disclosure:**
    - I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by Saint Alphonsus Health System /Trinity Health policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at Saint Alphonsus Health System to gain access to my own PHI in medical and other records.
    - I will not use another person’s, login ID, password, other security device or other information that enables access to Saint Alphonsus Health System/Trinity Health's computer systems or applications nor will I share my own with any other person.
    - If my employment or association with Saint Alphonsus Health System/Trinity Health ends, I will not subsequently access, use or disclose any Saint Alphonsus Health System/Trinity Health Confidential Information and will promptly return any security devices and other Trinity Health property.

- I will not engage in any personal use of Saint Alphonsus Health Systems' computer systems that inhibits or interferes with the productivity of employees or others associated with Saint Alphonsus Health System/Trinity Health's operations or business, or that is intended for personal gain;
- I will not engage in the transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission, values, policies or procedures of Saint Alphonsus Health System/Trinity Health;
- I will not utilize the Saint Alphonsus Health System /Trinity Health network to access Internet sites that contain content that is inconsistent with the mission, values and policies of Saint Alphonsus Health System/Trinity Health.

3. Accountability and sanctions:

- I will immediately notify the Saint Alphonsus Health System /Trinity Health Security Official or Privacy Official if I believe that there has been improper/unauthorized access to the Saint Alphonsus Health System/Trinity Health network or improper use or disclosure of confidential information in electronic, paper or oral forms.
- I understand that Saint Alphonsus Health System/Trinity Health will monitor my access to, and my activity within, Saint Alphonsus Health System/Trinity Health's computer system, and I have no rightful expectation of privacy regarding such access or activity.
- I understand that if I violate any of the requirements of this agreement, I may be subject to disciplinary action up to and including termination, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.
- If I lose my security device I will report the loss to the Trinity Health Resolution Center immediately and I may be charged for its replacement.

4. Software use:

- I understand that my use of the software on Saint Alphonsus Health System/Trinity Health's network is governed by the terms of separate license agreements between Trinity Health and the vendors of that software.
- I agree to use such software only to provide services to benefit Trinity Health.
- I will not attempt to download, copy, or install the software on any other computer.
- I will not make any change to any of Trinity Health's systems without Trinity Health's prior express written approval.

5. Network:

- I understand that access to Saint Alphonsus Health System/Trinity Health's network is "as is", with no warranties and all warranties are disclaimed by Trinity Health.
- Trinity Health may suspend or discontinue access to protect the network or to accommodate necessary down time. In an emergency or unplanned situation Trinity Health may suspend or terminate access without advance warning.
- Trinity Health may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason.

6. Employer acceptance of responsibility for an individual with access to Confidential Information:

(Applies to physicians/physician practices; other individual or facility providers; a vendor that is not a business associate; payers; any other unaffiliated organization).

- I accept responsibility for all actions and/or omissions by my employees and/or agents
- I agree to notify the Trinity Health Resolution Center within 5 business days if any of my employees or agents who have access to Trinity Health systems or applications no longer need or are eligible for access due to leaving my practice/company, changing their job duties or for any other reason.
- I agree to report any actual or suspected privacy or security violations made by my employees and/or agents to the Saint Alphonsus Health System/Trinity Health Privacy Official or Security Official.
- I understand that Saint Alphonsus Health System/Trinity Health may terminate my employee and/or agent's access.

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SIGNATURE PAGE - RELATIONSHIP TO SAINT ALPHONSUS HEALTH SYSTEM/TRINITY HEALTH

I am a: (Please check all that apply to you)

☐ Associate (employee) with Saint Alphonsus Health System
☐ Physician Credentialed on (Saint Alphonsus Health System) Medical Staff
☐ Volunteer at the Saint Alphonsus Health System Facility
☐ Temporary/Contractor at the Saint Alphonsus Health System Facility: (name of agency) _____
☐ Student at Saint Alphonsus Health System: (name of educational organization) _____

Employed by or Associated with a Saint Alphonsus Health System Credentialed Medical Staff Member

☐ Medical Staff Member's Employee or Temp Staff (name of practice) _____
☐ Medical Staff Member's Vendor's Employee (name of vendor _____

Vendor Providing Goods or Services to Saint Alphonsus Health System

☐ Employee/Temp Staff of SAHS clinical services vendor: (name of vendor) _____
☐ Employee/Temp Staff of SAHS business services vendor: (name of vendor) _____
☐ Employee/Temp Staff of SAHS IT services vendor: (name of vendor) _____

(Saint Alphonsus' Joint Venture or a Facility Managed by Saint Alphonsus Health System

☐ Employee of a SAHS Joint Venture (name of joint venture) _____
☐ Employee of a Hospital/Other Facility Managed by SAHS (name of facility) _____
☐ Credentialed Physician on Medical Staff of a Hospital/Other Facility Managed by SAHS:
(name of facility): _____
☐ Employee or Temp Staff of a Credentialed Physician on the Medical Staff of a Hospital/Other Facility Managed by SAHS: (name of physician's practice) _____

Other

☐ Unaffiliated (non-credentialed) Physician/Other Provider: (name of practice) _____
☐ Employee of an Unaffiliated Physician or Facility: (name of practice or facility) _____
☐ Employee of a Payer: (name of payer) _____
☐ Researcher (Research study name): _____
☐ Other (name of employer) _____

USER SIGNATURE

If there are any items in this agreement that I do not understand I will ask my Saint Alphonsus supervisor or other appropriate Saint Alphonsus contact person for clarification. My signature below acknowledges that I have read, understand and accept this agreement and realize it is a condition of my employment or association with Trinity Health. I also acknowledge that I have received a copy of the Confidentiality and Network Access Agreement.

_____

Print Name | Signature of individual to be given access | Date

EMPLOYER SIGNATURE (Required)

When user is an employee or agent of: a physician/physician practice; other individual or facility provider; a vendor that is not a business associate; any other organization unaffiliated with Saint Alphonsus Health System or Trinity Health. My signature below acknowledges that I have read, understand and accept my responsibilities as the employer or the sponsor of the user who has signed this agreement above.

_____

Print Name

_____

Signature of employer of the individual to be given access | Date

Please return the original document to your local OTE/HR Department.