



Non-St. Luke's Employee CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT

I understand that I may have access to St. Luke's confidential information (defined below). I understand that this access is a privilege and is limited by the terms of this agreement. I agree to follow the terms of this agreement at all times. I know if I break this agreement, I will be subject to disciplinary action.

"Confidential information" includes all information, in all formats:

1. Related to patients;
2. About St. Luke's that is not available to the general public;
3. About companies or people working with St. Luke's that is not available to the general public; and
4. About St. Luke's employees.

What you are agreeing to:

1. I will not use confidential information in any way that may harm St. Luke's, its patients or its employees.
2. I will only access, use, and share confidential information as allowed and as required to perform my job duties.
3. I will only share confidential information with people who have to follow this agreement and who need the information to do their jobs.
4. I agree not to change software or to use software except as needed by St. Luke's.
5. I will not access, use or share confidential information for personal reasons or for any purpose not allowed by St. Luke's, including information about co-workers, me, family members, friends, neighbors or celebrities.
6. I understand that I will be given a username and password and that they are the same as my legal signature. I will not share my username or password with anyone. I will not let anyone use a computer without me there when I am logged in.
7. I will not try to learn or use someone else's password.
8. If I think someone else knows my password, I will change my password and contact the Information Technology Department right away.
9. I will protect all confidential information by:
 - a) Not leaving paper records where unauthorized people may view them;
 - b) Using password protection, screensavers, time-outs or other security measures to secure my workstation or other device when I am away;
 - c) Disposing of confidential information in a way that will prevent a break in confidentiality.
10. I will attend training sessions and follow state and federal laws and regulations, this Agreement and St. Luke's policies and procedures which relate to my access to, or use of, confidential information, including off-site (remote) access.
11. I understand that St. Luke's monitors activity within St. Luke's network(s). My use of the network(s) is not private.
12. If it is determined that I violated this agreement, my access may be limited, suspended or terminated and I may be subject to disciplinary action, up to and including immediate termination. I may also be subject to civil and/or criminal penalties.

13. If my relationship with St. Luke's ends for any reason, I agree to return all confidential information. I will also return all computer hardware (laptops, PC's, USB thumb drives, cables, PDA's, etc.) and software that I have.
14. Even after I leave St. Luke's I understand that I may not use or disclose confidential information.
15. If I manage others, and a person I supervise no longer needs access to confidential information, I agree to follow the process at my site for removing this access.
16. I agree to report when confidential information is not accessed or used appropriately. These events should be reported to the Privacy Officer where the event occurred.

I have received a copy of this agreement and have been given enough time to ask questions about it. My signature below means that I have read, understand and agree to follow this agreement as a condition of my association with St. Luke's.

Check one of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Physician Medical Student | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Nurse Practitioner Medical Student | <input type="checkbox"/> Payor Employee |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Physician Assistant Medical Student | <input type="checkbox"/> Vendor |
| <input type="checkbox"/> Allied Health Provider (Medical Staff Office defined) | | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Physician Office Staff | <input type="checkbox"/> Nurse | <input type="checkbox"/> Nursing Student |
| <input type="checkbox"/> Temporary Contractor | | |
| <input type="checkbox"/> Other/Outside Affiliate _____ | | |

Any INCOMPLETE Form will NOT be Processed (Use N/A, if not applicable)

Name: (Last, First, Middle Initial)	Last 5 Digits of your Social Security Number (Used for account verification):	Practice/Company Name:
Email:	Job Title:	Practice/Company Address:
Phone:	Fax:	St. Luke's Username, if applicable:
Office Manager or Physician Contact Information		
Name:	Email:	

Signature

Date/Time

Fax both pages of this agreement to: 208-381-8701