

CONFIDENTIALITY AGREEMENT

As an employee, volunteer, student, or other person affiliated with Alegent Health, you may have access to what this agreement refers to as "Confidential Information." The purpose of this agreement is to help you understand your responsibility regarding confidential information.

Confidential information includes patient, employee, volunteer, student, financial information, and other information proprietary to Alegent Health facilities or persons. You may learn or have access to some or all of this confidential information through a computer system or through your activities at Alegent Health.

You are required to conduct yourself in a manner which is consistent with Alegent Health Policies and Procedures. By reading and signing this agreement, you agree to the following:

- I will use confidential information only as needed to perform my legitimate duties.
- I will only access confidential information for which I have a need to know.
- I will not in any way divulge, copy, release, sell, lend, review, alter, or destroy confidential information except as properly authorized within the scope of my assigned duties affiliated with Alegent Health, and will be held accountable for the misuse or wrongful disclosure thereof.
- I will not misuse confidential information or carelessly care for confidential information.
- I will report any activity by individuals whose actions compromise the confidentiality of information to either my department management or the Alegent Health Information Security Administrator.
- My obligation under this agreement will continue after termination of my employment, voluntary association, or student experience.
- At all times during my affiliation with Alegent Health, I will safeguard and retain the confidentiality of confidential information. I understand that I do not have right or ownership interest in any access, password, or other authorization to confidential information.
- I will safeguard and not disclose my password or any other authorization which allows access to confidential information.
- I will be accountable for the misuse or wrongful disclosure of confidential information obtained through the use of my sign-on and password.

I acknowledge that I understand and agree that if I should not abide by this agreement, disciplinary actions up to and including termination of my affiliation with Alegent Health, will result.

Signature (Employee/Volunteer/Student/Person Affiliated with Alegent Health)	Department/Associated Business Entity
Printed Name	Date
Title	Employee ID