CLAY COUNTY
MEDICAL
CENTER

I understand that as a:

_____Clergy
_____Visitor/Observer/Student/Instructor
_____Outside Peer Reviewer
_____Other (designate status:_____)

at Clay County Medical Center I am subject to Clay County Medical Center's Policies related to HIPAA Privacy and Security compliance, and other policies related to the use or disclosure of confidential information. I understand that confidential information consists of verbal, written and observed information including patient information (including patient name and the fact the patient is receiving services), information technology information, risk management information, proprietary information and business information. I agree to abide by all Clay County Medical Center policies, to not access, acquire, use or disclose confidential information except as specifically authorized by Clay County Medical Center. I agree to report any suspected or actual unauthorized use, disclosure, acquisition or access to confidential information, or any loss of a mobile device (laptop, PDA, smart phone, flash drive, disc, etc.) that contains confidential information. I agree that I will not use, disclose, transmit or post information that violates the HIPAA privacy and security regulations, peer review laws or risk management laws to any social networking site, website, blog, tweet, microblog, or similar site or function. I further agree that if I am provided access credentials that I will not disclose or share those credentials.

I understand that some penalties for breaches of confidentiality are subject to certain provisions of state and federal laws. I understand that breach of Clay County Medical Center's policies related to HIPAA Compliance, or the maintenance of other confidential information, may result corrective action that may include immediate termination of my status.

By signing this statement, I am stating that I have read and understand the confidentiality of information provisions contained in the Notice of Privacy Practices and that I have access to all pertinent Clay County Medical Center policies and agree to abide by their terms and conditions.

Signature: _____ Date:_____