PP-20a Attachment E
Rev. 7/30/2013

Non-UW Workforce Privacy, Confidentiality and Information Security Agreement

Access to UW School of Dentistry Electronic Health Record (EHR) systems is permitted to authorized users to view protected health information (PHI) electronically. Access is provided only to those individuals whose access has been approved by a UW School of Dentistry Administrator or Director or under a Business Associate Agreement.

A. Non-UW School of Dentistry Workforce Information:

Name _____

Organization _____

Address _____

City _____ **State** _____ **ZIP**_____

Phone number _____ **Fax:** _____

Email _____

B. Privacy, Confidentiality, and Information Security Acknowledgement

UW School of Dentistry has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Federal and state laws and regulations govern the privacy of our patients and their health information. In the execution of services by the organization, I will or may see patients with a variety of health issues and/or may see and hear confidential information relating to these patients. This relates to information past, present and future physical or mental health or condition of an individual. As a condition of accessing UW School of Dentistry PHI, I understand and agree that:

- I will comply with federal and state statutory and regulatory requirements (including 45 CFR Parts 160 and 164 (HIPAA) and RCW 70.02).
- I agree to safeguard my UW School of Dentistry access account, and password. I will not share my password with any other person and will not permit others to access the UW School of Dentistry systems through my account. I understand that I will be held accountable for all accesses made under my login and password and any activities associated with the use of my access privileges.
- I will log out or lock computer sessions prior to leaving a computer.
- I understand that I am being given access to PHI and that my access will only occur according to the contract signed by UW School of Dentistry and the company I represent. The information disclosed under this agreement will be only used for the purpose(s) described in that contract.
- I understand that my access will be monitored to assure appropriate use.
    - I understand that the Secretary of the Department of Health and Human Services or the Washington State Attorney General may investigate complaints and may seek criminal prosecution or impose civil monetary penalties to my company and/or me for inappropriate uses or disclosures of certain protected health information.
- I will limit my access, use, and disclosure of patient information to the minimum amount necessary to perform my authorized activity or duty. I understand that the patient information I access is confidential and will not copy or disseminate except as authorized or allowed or required by law. I will only discuss patient, confidential, or restricted information only with those who have a need-to-know and the authority to receive the information.
    - I will keep protected information taken off-site fully secured and in my physical possession during transit, never leaving it unattended or in any mode of transport (even if the mode of transport is locked). I will only take protected information off-site if accessing it remotely is not a viable option.
    - I will store all protected health information on secured systems, encrypted mobile devices, or other secure media.
    - I agree that if I terminate my position with the my company or no longer work in my current position, or otherwise am no longer functioning in the role under which access was granted, I, or my company, will immediately notify UW School of Dentistry IT Services Help Desk at 206-616-3591 or email sodit@uw.edu and request that my access be deactivated.
- I agree to abide by this agreement and understand that these are privileges granted by UW School of Dentistry to me. I further understand and acknowledge that UW School of Dentistry may terminate this privilege at any time.
    - I will report all concerns about inappropriate access, use or disclosure of protected information, and suspected policy violations to UW School of Dentistry Compliance (206-543-5331 or dcomply@uw.edu).

_____ _____

Signature **Date**

C. Agreement to be retained by UW School of Dentistry Department

I understand that I will be responsible for this individual when they are accessing PHI and acknowledge that their access to PHI is in compliance with UW School of Dentistry Privacy Policies.

Name: _____ *Signature*_____

Title: _____ *Phone number:* _____ *Date:* _____