HEALTH INFORMATION CONFIDENTIALITY AGREEMENT

As an employee of Grant County Fire Protection District No. 3 or as a volunteer firefighter, subcontracted employee, student, observer, or visiting professional, I understand that I may have access to Patient Health Information during the normal course of my work. This information could be in several different forms including; written paper forms, electronic data on computer screens, audio and video recordings, audio and data transmissions over radios and pagers and telephones, faxes, notes, and verbal reports. Examples of Health Information include but are not limited to; names, addresses, telephone numbers, medical conditions, medical histories, medical treatments, prescription drug therapy, sexual behaviors, drug-use behaviors, psychological conditions and treatment, finances, living arrangements, religious beliefs, and social history. Health Information includes "health care information," "individually identifiable Health Information" and "protected Health Information" as those terms are defined in HIPAA and the Washington State Health Care Information Act.

By signing this statement, I am indicating my understanding of my responsibilities and agree to the following:

1. I agree to follow and comply with the confidentiality and security policies specific to my work site and job description.

2. I will treat all Patient Health Information received by me in the course of my duties as confidential and privileged information at all times.

3. I understand that all Patient Health Information and records compiled, obtained, or accessed by me in the course of my work are confidential.

4. I agree not to divulge, disclose, publish, or otherwise make known to unauthorized persons, or to the public, any Health Information relating to any Patient of the District.

5. I agree not to divulge, disclose, publish, or otherwise make known to unauthorized persons, or to the public, any Health Information obtained from other health care providers except as necessary to my job duties.

6. I understand that I am not to read Health Information concerning Patients nor ask questions of Patients during interviews for my own personal information but only to the extent necessary and for purpose of performing my assigned duties. I will not access Patient Health Information unless I have a specific need to know this information in order to perform my duties.

7. I will not access any of the District's computer systems that currently exist, or may exist in the future, with a password other than my own and I will not allow use of my password by other personnel.

8. I will not use e-mail to transmit Patient Health Information unless I am specifically instructed to do so by the District's Privacy Officer.

9. I will not take Patient Health Information from the premises of the District in paper or electronic form without first receiving specific permission from the District's Privacy Officer.

10. For purposes of maintaining training and skills maintenance records for my continuing recertification and education I shall record the minimum necessary Health Information so that it will in no way identify the Patient or the Patient's condition.

11. I understand that unauthorized disclosure of Health Information may be a violation of the Washington State Health Care Information Act and the federal Health Insurance Portability and Accountability Act. I understand that a breach of security or confidentiality may be grounds for disciplinary action up to and including termination of employment.

12. I understand that action to impose civil or criminal penalties against me may be taken by a prosecuting attorney or another party with standing if I am suspected of being responsible for a breach of confidentiality, or unauthorized disclosure of Health Information.

13. I agree to notify my supervisor immediately should I become aware of actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my or on the part of another person.

14. Upon cessation of my employment relationship with the District, I agree to continue to maintain the confidentiality of any Health Information I acquired while performing my duties with the District. I agree to return my keys, access cards or other devices that would provide access to the District's facilities or Patient Health Information.

I understand that a violation of this Agreement will result in disciplinary action, including termination.

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Employees Name PRINTED Date

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Employees Signature