Central Florida Health Alliance
Leesburg Regional Medical Center
The Villages Regional Hospital
Leesburg Rehabilitation Hospital

CENTRAL FLORIDA HEALTH ALLIANCE
COMPUTER ACCESS AND CONFIDENTIALITY AFFIDAVIT
FOR NON-EMPLOYEES

I understand that my login ID is the equivalent of my legal signature, and I will be accountable for all representations made at log in and for all work done under my login ID. I understand that the electronic data and information stored in the computer systems are confidential patient, financial, organizational, and practitioner data or information and I must treat them with the same care as data and information in the paper records.

I agree to respect and abide by all federal, state and local laws pertaining to the confidentiality of identifiable medical, personal and financial information obtained. I agree to adhere to all policies and procedures adopted to comply with the Health Insurance Portability and Accountability Act (HIPAA) governing the privacy, security and use of protected health information. I will agree to amend this Affidavit or any separate agreement governing the exchange of demographic, insurance and billing information, as needed, to comply with such rules.

I will not access data for which I have no patient care or peer review responsibilities as defined in the Medical Staff bylaws and/or rules and regulations of the hospital(s) at which I have privileges.

I understand that all information that may identify who the patient is, or relates to the patient's health must be maintained in strict confidence. I will not speak about or disclose any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, other than as permitted by the Hospital.

I agree to use and disclose confidential patient information only for the purpose of patient care, billing or other HIPAA approved operational reasons.

I will not use or disclose any patient information for any purpose other than a purpose stated in this Affidavit. I understand that I am not authorized to disclose any information related to patient information to anyone outside The Hospital, unless otherwise permitted by this Affidavit.

I will make sure all patient information in any form is returned to The Hospital, or destroyed in manner that renders it unreadable and unusable by anyone else.
I agree to report immediately to the Hospital any non-permitted use or disclosure of confidential patient information made in error and to report any use or disclosure of confidential patient information made by others that may be a wrongful disclosure.
If I believe someone has compromised or broken the security of my login ID and password, or I no longer need access to the computer systems, I will immediately contact the Information Technology Department for the Central Florida Health Alliance, who will make arrangements for another password to be assigned or to terminate my

access, as applicable.
I understand that the misuse of my access to the computer systems of the Central Florida Health Alliance or its affiliated entities or of confidential information obtained, may subject me to disciplinary action and immediate termination of my access rights.
I understand that state and federal laws protect the confidentiality of this information and that I will be personally liable for any breach of these duties and may also be held criminally liable under the HIPAA privacy regulations for intentional and malicious release of identifiable health information.

I agree to report immediately to the Hospital any non-permitted use or disclosure of confidential patient information made in error and to report any use or disclosure of confidential patient information made by others that may be a wrongful disclosure.
I agree to cooperate with any investigation by the Secretary of Health and Human Services, or his agent, or an oversight agency, to help them determine if The Hospital is complying with federal or state privacy laws.

Signature of User: _____

Printed Name: _____

Office Title: _____

Name of Physician for whom you work (if applicable): _____

Name of Company or Organization: _____

Address: _____

_____

Phone: _____

Date of Birth:
(mm/dd/yy): _____

Date: _____