

VIDANT HEALTH CONFIDENTIALITY AGREEMENT

I understand that all patient information, all information regarding employees and contracted personnel, all competitive healthcare information (information not known or readily ascertainable to the public) and all information Vidant Health and its subsidiaries (collectively referred to as "Vidant Health") are required by law to keep private (collectively referred to as "confidential information"), in whatsoever form (including but not limited to electronic and/or digital format, printed, written, and/or spoken) is confidential. I agree not to disclose, repeat, reveal or share any confidential information with anyone else unless I receive the express written permission of Vidant Health or I am required by state or federal law or permitted by internal Vidant Health policy; provided, however, I may disclose private health information for treatment, payment or health care operations and confidential information to others who need to know within Vidant Health in accordance with Vidant Health policies. I further understand and agree that I will only access such confidential information as reasonably needed for me to perform my job or my contracted responsibilities.

I agree to take all necessary and reasonable steps to prevent and limit the improper or unauthorized disclosure or misuse of confidential information including, but not limited to, keeping confidential information private and out of public viewing; securing or protecting information on my computer when leaving my workstation; copying or downloading data only to secured locations and only when required to perform job duties and not discussing confidential information in public areas.

I agree to abide by all Vidant Health policies regarding confidentiality and security of confidential information currently in effect and which may be amended from time to time. I further agree to comply with all applicable state and federal laws governing access to computer systems and protection of confidential information.

I accept complete responsibility for my actions, and I understand that any violation of this Confidentiality Agreement may result in immediate revocation of my access to confidential information, removal from Vidant Health premises, disciplinary action up to and including termination of employment, ability to provide services, and/or revocation of my ability to practice at Vidant Health. (A member of the Medical Staff is subject to disciplinary action in accordance with Medical Staff Bylaws.)

My signature attests to the fact that I have read, understand and agree to abide by the terms of this Confidentiality Agreement.

Date: ____/____/____

Signature: _____

Non-Vidant Employee (Medical Student)

Name
(print): _____

Employer: Office of Student Affairs, BSOM

Employer Phone: (252) 744-2278