OSF HEALTHCARE

OSF HealthCare
Confidentiality Agreement

This Agreement is entered into at the time of, in consideration for, and in connection with the issuance of a user name and security password by OSF HealthCare to the individual named below ("User") which will enable them to access confidential and sensitive information. The protection of the privacy, security and confidentiality of information is a matter of concern for all persons who have access to confidential and sensitive information. Each person accessing this information holds a position of trust relative to this information and must recognize the responsibilities entrusted to them in preserving the privacy, security, and confidentiality of this information.

Confidential and sensitive information is defined as: patient information, health plan member information, employee information, financial information, and/or business information. Confidential and sensitive information may be accessed in a variety of ways including: the OSF electronic information systems or paper records.

Members of the OSF workforce will not use or disclose the contents of any record or report except as necessary and appropriate and as permitted by federal, state, and local laws and to comply with all applicable policies of OSF HealthCare. This includes both paper and electronic records. Furthermore, it is recognized that confidential and sensitive information will only be disclosed to those authorized to receive it.

Electronic Users hereby agree:

1. To undergo training and orientation to the electronic information system designated by OSF prior to using a Password.
2. That I am the only person with access to my User ID and Password and the only person authorized to use this User ID and Password.
3. That I will not under any circumstances convey or disclose my User ID and/or Password which has been assigned to me by OSF to another person, except Service Center staff during problem resolution. Following the service call, I agree to promptly change my password.
4. That my Password and electronic signature code combination is the equivalent of my signature and that I am accountable for all entries and actions recorded under them.
5. That I will not attempt to access any information including confidential or sensitive information by using a Password other than my own.
6. That I will authenticate each report and entry separately and only after verification of the accuracy of its content.
7. That I am responsible for locking or logging out of the information systems prior to leaving the area and that I will not leave a display device that I have logged onto unattended.
8. Upon my termination from employment or upon the termination of my relationship with OSF, or the revocation or termination of this Agreement, or the revocation of my assigned Password, I will not attempt to access any information including confidential and sensitive information from the OSF information systems by using my assigned Password or any other Password required to access such information.

All Workforce Members agree:

1. That I will complete Privacy and Security training during orientation and at other times specified by OSF.
2. That I will use any information, including confidential and sensitive information only as needed to perform my legitimate duties. This means among other things that:
    - I will only access any information, including confidential and sensitive information that is necessary for the performance of my job.
    - I will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any information including confidential and sensitive information except as properly authorized within the scope of my job duties.
3. That I will report any suspected privacy or security violations to my immediate supervisor as soon as possible.
4. The responsibility to protect the confidentiality of information does not end when I terminate employment with OSF.

USER:

Name: _____

Date: _____

Signature: _____

Revised: February 2006
Revised October 2007

Emergency Contact

Employee Name (Print): _____

Employee ID Number: _____ Department: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: (_____) _____ - _____

_____ _____

Employee Signature Date

Pat Quinn
Governor

Erwin McEwen
Director

Illinois Department of Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number (1-800-25A-BUSE) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
Rev. 1/2009

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701