



**PARTNERS HEALTHCARE SYSTEM, INC.
PARTNERS COMMUNITY HEALTHCARE, INC.**

CONFIDENTIALITY AGREEMENT

Partners HealthCare System, its affiliates, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates, and Partners Community HealthCare must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code ["USER ID(s)" and PASSWORD(s)] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. I agree not to disclose or discuss any patient, human resources, payroll, fiscal, research and/or management information with others, including friends or family, who do not have a need-to-know.
2. I agree not to access any information, or utilize equipment, other than what is required to do my job, even if I don't tell anyone else.
3. I agree not to discuss patient, human resources, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
4. I agree not to make inquiries for other personnel who do not have proper authority.
5. I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
6. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner's computer systems to unauthorized locations, e.g. home.
7. I agree to log off prior to leaving any computer or terminal unattended.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any "USER ID" and/or PASSWORD to be issued to me, this form must be completed. I further understand that computer access activity is subject to audit.

Please indicate the institution(s) with which you are affiliated:

- | | | | |
|--------------------------|---------------------------------------|--------------------------|------------------------------------------|
| <input type="checkbox"/> | <i>Brigham and Women's Hospital</i> | <input type="checkbox"/> | <i>North Shore Medical Center</i> |
| <input type="checkbox"/> | <i>Dana-Farber Cancer Institute</i> | <input type="checkbox"/> | <i>Partners HealthCare System</i> |
| <input type="checkbox"/> | <i>Massachusetts General Hospital</i> | <input type="checkbox"/> | <i>Partners Community HealthCare</i> |
| <input type="checkbox"/> | <i>McLean Hospital</i> | <input type="checkbox"/> | <i>Spaulding Rehabilitation Hospital</i> |
| | | <input type="checkbox"/> | <i>Other: _____</i> |

Signature of Employee / Physician / Student / Volunteer

Date

Print Name

To Be Filed in Employee's Personnel Record