

## Security and Confidentiality Agreement

UF Health\* has a legal responsibility to safeguard the security and confidentiality of our patients' protected health information (PHI) as well as operational, proprietary and employee information. This information may include, but is not limited to, patient health records, human resources, payroll, fiscal, research and strategic planning and may exist in any form, including electronic, video, spoken or written. This agreement applies to all members of the workforce, including but not limited to, employees, volunteers, students, physicians and third parties, whether temporary or permanent, paid or not paid, visiting or designated as associates, who are employed by, contracted to, or under the direct control of UF Health. This agreement also applies to users of UF Health information systems and the information contained therein, whether the user is affiliated with UF Health or not, and whether access to or use of information systems occurs locally or from remote locations. I hereby agree as follows:

- I acknowledge that UF Health has formally stated in policy its commitment to preserving the security and confidentiality of health information in any format. I understand that I am required, if I have access to such health information, to maintain its confidentiality and security.
- I understand that access to health information is limited to those who have a professional need to know the information accessed, viewed, or shared. I understand that I may not use the Epic access granted to me to perform my duties to access my own Epic record.
- I understand that UF Health has implemented administrative, technical, and physical safeguards to protect the confidentiality and security of PHI, and I agree not to bypass or disable these safeguards.
- I understand that I will be given a unique User ID and password to access electronic health, operational, proprietary, employee or other confidential information. I understand that my User ID and password are confidential, that I am responsible for safekeeping my password, that I am also responsible for any activity initiated by my User ID and password, and that my User ID and password are equivalent to my legal signature.
- I have no expectation of privacy when using UF Health information systems. UF Health may record, audit, log and/or monitor access to or use of its information systems. I agree to practice good security measures on any computing device that uses or accesses a UF Health information system. Good security measures include, but are not limited to, maintaining physical security of electronic devices, never leaving a device unattended while in use, and adequately shielding the screen from unauthorized viewing by others.
- I understand that portable devices such as USBs used to transport PHI must be encrypted.
- I understand that smartphones and other mobile devices used to access UF Health information systems must be configured to encrypt any Restricted or Sensitive Data, including photographs and videos, in persistent storage.
  1. *Restricted Data:* Data in any format collected, developed, maintained or managed by or on behalf of UF Health, or within the scope of UF Health's activities, that are subject to specific protections under federal or state law or regulations or under applicable contracts (e.g., medical records, Social Security numbers, credit card numbers, Florida driver licenses and export controlled data).
  2. *Sensitive Data:* Data whose loss or unauthorized disclosure would impair the functions of UF Health, cause significant financial or reputational loss, or lead to likely legal liability (e.g., financial information, salary information, hospital policies, research work in progress, and copyrighted or trademarked material).
- I understand that upon termination of my employment / affiliation / association with UF Health, I will immediately return or destroy, as appropriate, any Sensitive or Restricted Data in my possession. I understand that my confidentiality obligations under this Agreement will continue after the termination of this Agreement and after termination of my employment or affiliation with UF Health.
- I agree to immediately report any known or suspected violations of the confidentiality or security of PHI of patients of UF Health to either UF Health IT or to the UF Health Privacy Office.
- I understand that violations of this Agreement may result in revocation of my user privileges and/or disciplinary action, up to and including termination, and that UF Health may seek any civil or criminal recourse and/or equitable relief.

By signing or by entering my name and other identifying information on this Agreement, I acknowledge that I have read this Agreement and agree to comply with all the terms and conditions stated above.

Print Name	Entity or Department	
Signature	Date	Badge # or UF ID #
E-mail		

\*For purposes of this form, "UF Health" describes a collaboration of the University of Florida Board of Trustees for the benefit of the UF College of Medicine; UF clinics and physicians' offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc.; the University of Florida Jacksonville Healthcare, Inc.; the UF Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the UF Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other UF health services staff; Shands Jacksonville Medical Center, Inc.; Shands Teaching Hospital and Clinics, Inc.; and Shands Recovery, LLC.