HIPAA Confidentiality Certification

The Federal Government through its Health Insurance Portability Act, commonly referred to as HIPAA, requires all persons who deal with personal health information to protect such information from public disclosure. A person's health information, including their plan(s), pre-existing conditions, health conditions, treatment and utilization data or other information that is personal and private to them is protected under the "Protected Health Information" elements of the HIPAA laws. The laws are broadly interpreted to include the following:

Health care claims or equivalent encounter information;
Eligibility for a health plan;
Referral certification and authorization;
Health care claim status;
Health plan premium payments;
Coordination of benefits; and,
Enrollment and dis-enrollment in a health plan.

As an officer, director, employee of Wood County employed in a position with exposure to protected health information of the nature listed above you will be in possession of such protected health and Trade Secret information. In order to protect yourself, Wood County, and Business Associates of Wood County, it is necessary that you agree to follow the Health Plan Confidentiality Rules.

CONFIDENTIALITY AGREEMENT

I understand that Wood County as Plan Sponsor of the Employee Health Benefits Program and Business Associates of the Plan has legal and ethical responsibilities to safeguard the privacy of all Plan Participants and to protect the confidentiality of their protected health information. Additionally, Wood County must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information (collectively "Confidential Information").

In the course of my employment/assignment as an employee of Wood County working with the Health Benefits Program, I understand that I may come into the possession of Confidential Information.

I further understand that I must agree, sign and comply with all elements of this agreement to get authorization for access to any of the Plan's Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. In addition, I understand that my personal access code, user ID(s), and password(s) used to access computer systems are also an integral aspect of this Confidential Information.

2. I will not access or view any Confidential Information or utilize equipment, other than what is required to do my job.

3. I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on the shuttle bus, on public transportation, at restaurants, and at social events). It is not acceptable to discuss Confidential Information in public areas even if a patient or subscriber's name is not used. Such a discussion may raise doubts among participants about our respect for their privacy.

4. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.

5. I will not 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 will not make any unauthorized transmissions, inquiries, or modifications of Confidential Information of the Wood County Health Plan's computer system. Such unauthorized transmission include but are not limited to, removing and/or transferring Confidential Information in the Health Plan's computer system to unauthorized locations (for instance, home).

7. I will log off any computer or terminal prior to leaving it unattended.

8. I will comply with any security or privacy policy promulgated by the Wood County Health Plan to protect the security and privacy of Confidential Information.

9. I will immediately report to the HIPAA Privacy Officer, Pamela Boyer any activity, by any person, including myself, that is a violation of this Agreement or of any Wood County Health Plan information security or privacy policy.

10. Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information to the Wood County Health Plan.

11. I agree that my obligations under this Agreement will continue after the termination of my employment.

12. I understand that violation of this Agreement may result disciplinary action, loss of computer access privileges as well as legal liability.

13. I further understand that all computer access activity is subject to audit.

By signing this document I understand and agree to the following:
I have read the above agreement and agree to comply with all its terms.

Signature of employee: ____________________________________ Date: ___________

Print Name: ____

Classification: ____