Cape Cod Healthcare
CONFIDENTIALITY AGREEMENT

Consistent with applicable state and federal laws, the Principles of Ethics of both the American Medical and Hospital Associations, and established Cape Cod Healthcare, Inc. ("CCHC") policies and procedures, individuals who are given access to CCHC records (whether medical, financial or other) as well as all users of the CCHC Information System (the "CCHCIS"), must acknowledge and agree that they will safeguard and protect all such records and information from inappropriate use or disclosure. You acknowledge that all such records are confidential and/or proprietary to CCHC, whether stored in hard copy, film or computerized/electronic form, and that the unauthorized access, use, disclosure or dissemination of such information is strictly prohibited.

CCHCIS user codes and passwords will be issued on a private, individualized basis. These codes and passwords are not to be shared with anyone else, and it is your responsibility to protect and safeguard those codes/passwords from unauthorized use. Your password is a unique code which identifies your identity for and within the CCHCIS. All activities, performed using this password, such as, inquiries, data entries and orders, are recorded and will be attributable to you. The CCHCIS can and will be monitored frequently and without advance notice for inappropriate access to individually identifiable health information ("PHI – Protected Health Information") and for other purposes.

All PHI and other data and information stored on the CCHCIS are the exclusive property of CCHC. Because virtually all of that information is or will become a part of a patient's legal medical record, all CCHC policies, legal restrictions and ethical guidelines applicable to patient medical records, PHI and other protected clinical, financial and administrative information also apply to the data stored at and within CCHC as well as on the CCHCIS.

By signing where indicated below, you acknowledge your legal obligation to maintain the confidentiality of PHI and other patient and CCHC records. You further acknowledge that accessing patient and/or CCHC system information which is not essential to the performance of your duties for and within CCHC, disclosing your system identifier and/or password to another, allowing access to the CCHCIS by unauthorized individuals and/or entities whether intentional or unintentional, or any other breach of patient record or health care system confidentiality policy will be investigated and the consequences could be severe for you, up to and including your termination as an employee of CCHC and/or the permanent loss of your ability to access CCHCIS.

Should a Medical Staff Member of a CCHC affiliated hospital or an employee of that Medical Staff Member, disclose PHI or other information obtained from CCHC or the CCHCIS in an unauthorized manner, in violation of applicable state and/or federal law or in violation of applicable CCHC policy and/or procedure (including those set forth in this Confidentiality Agreement), the Medical Staff Member, his/her employee as well as his/her employer shall remain obligated to indemnify and hold CCHC harmless from all claims, demands, suits and liabilities, including reasonable attorney's fees and costs that may be made or taken against CCHC for that breach.

Finally, by signing this Agreement you acknowledge your obligations with respect to those confidentiality obligations imposed upon CCHC and its affiliates pursuant to the Health Insurance Portability and Accountability Act of 1996, a law more commonly known as HIPAA. You agree to protect and safeguard PHI (as defined under HIPAA), and acknowledge your receipt of a copy of CCHC's Notice of Privacy Practices. You agree to abide by the provisions of that Notice. If at any time you have reason to believe that the confidentiality of CCHCIS or any other source of PHI may have been compromised at or within CCHC, you are required to notify your supervisor, manager, department head, or CCHC's Compliance Office immediately so that appropriate action can be taken.

I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING CONFIDENTIALITY AGREEMENT AND AGREE TO ABIDE BY ITS TERMS. *****ALL FIELDS ARE REQUIRED!!*****

Last Name	First Name	MI	Birthdate (MMDDYYYY)	Last four SSN (xxxx)
Job/Title	**Department/Office**	**Company/Facility**		**Office Telephone**
Signature:		**Date:**		

CAPE COD HEALTHCARE, INC.
OCCUPATIONAL HEALTH SERVICES (OHS)

Hyannis Office-26 Gleason St., Hyannis, MA 02601 - Phone: (774) 552-6100 Fax: (508) 771-6445
Falmouth Office-100 Ter Heun Dr., Falmouth, MA 02540 - Phone: (508) 457-3950 Fax: (508) 457-3793

SHADOWER IMMUNIZATION FORM
(Less than 8 hours)

"Providing the Highest Quality of Care to Our Employees"

Date: _____ Facility:_____Dept._____

Name: _____ Signature: _____
(PRINT) **(PARENT, IF STUDENT UNDER 18 YEARS OLD)**

School_____ Phone # or E-mail address:_____

Please fill out the information below to the best of your knowledge.

To be in compliance with JCAHO, MDPH and CDC, Cape Cod Healthcare, Inc. must have this information on file. This information will be kept confidentially in Occupational Health Services (OHS) as well as in the Human Resources/Education Office.

IMMUNIZATIONS	**YES**	**NO**
Have you had recent close contact with someone with infectious Tuberculosis disease?	❒	❒
Were you born outside the United States? If so, where were you born? _____	❒	❒
Have you had any of the following within the last year?	❒	❒
• Unexplained fever	❒	❒
• Unexplained cough for 3 weeks or more	❒	❒
• Drenching sweats at night	❒	❒
• Unexplained weight loss	❒	❒
• Chest pain	❒	❒
• Unexplained tiredness	❒	❒
• Coughing up blood	❒	❒
Have you ever had a positive Tuberculin Skin Test (TST) or TB test?	❒	❒
Have you received the Hepatitis B series?	❒	❒
Have you had the MMR (Mumps, Measles, German Measles) vaccine (2 doses) or the diseases?	❒	❒
Have you had chicken pox or the varicella vaccine?	❒	❒

I will be shadowing:_____ _____ _____
No. hrs. On this Date(s)

Reviewer Signature: _____ _____
Occupational Health Services Date

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