UW School of Dentistry Workforce Members

Privacy, Confidentiality, and Information Security Agreement

As a user of UW & UW School of Dentistry computing resources and data, I understand that I am responsible for the security of my User ID (login) (s) and Password(s) to any UW and/or UW School of Dentistry computer system for which I am granted access. I understand that it is my responsibility to protect my password's confidentiality. I understand that I have the following responsibilities:

- Comply with UW and UW School of Dentistry policies;
- Support compliance with federal and state statutory and regulatory requirements;
- Protect access accounts, privileges, and associated passwords (examples: Not sharing my password and Not logging on for others);
- Maintain the confidentiality of information to which I am given access privileges;
- Accept accountability for all activities associated with the use of my individual user accounts and related access privileges;
- Not to change the computer configuration unless specifically approved to do so;
- Not to disable or alter the anti-virus and/or firewall software;
- Not to download, install or run unlicensed or unauthorized software;
- Use only licensed and authorized software;
- Ensure that my use of UW & UW School of Dentistry computers, email, computer accounts, networks, and information accessed, stored, or used on any of these systems is restricted to authorized duties or activities;
- If I have clinical systems access, I may access my own PHI;
- Workforce members may not access the records of their family members, including minor children, nor any other person if not an assigned or job-related duty. This also applies in cases where workforce members hold authorizations or other legal authority from the Patient;
- Report all suspected security and/or policy violations to my Help Desk;
- Report all known privacy violations to the UW School of Dentistry Compliance Officer

I understand that where I have access to or use of information classified as RESTRICTED or CONFIDENTIAL, additional protections are expected. Proprietary information, which includes business plans, intellectual property, financial information or other sensitive materials and information in printed, electronic or verbal form that may affect any workforce member's rights or organizational operations, is an example of a RESTRICTED classification. Protected health information, which includes individually identifying patient information in any form, sensitive student information, and workforce records are examples of a CONFIDENTIAL classification.

I understand that any RESTRICTED and/or CONFIDENTIAL information collected or obtained from, analyzed, or entered into any UW School of Dentistry information management system(s) or database(s) is the property of UW School of Dentistry unless otherwise specified by contract. I understand that I must maintain and safeguard the confidentiality of any and all UW School of Dentistry RESTRICTED and/or CONFIDENTIAL information accessed or obtained in the performance of my authorized duties or activities. I will not access, use, and/or disclose RESTRICTED and/or CONFIDENTIAL information for any purpose other than the performance of authorized activities or duties. I will limit my access, use and disclosure to the minimum amount of information necessary to perform my authorized activity or duty.

I will safeguard all RESTRICTED and/or CONFIDENTIAL information by holding it in the strictest confidence and by refusing to allow others to access information unless my authorized activities require that I do so. In such cases, I will disclose or allow access only to individuals having appropriate authority to access, receive and use such information.

I understand that my access to systems that have RESTRICTED and/or CONFIDENTIAL information may be monitored to assure appropriate access and compliance with system integrity. I understand that authorized use carries with it the responsibility to follow the UW School of Dentistry Privacy and Information Security policies that govern the use of RESTRICTED and/or CONFIDENTIAL information, computers, and networks.

I understand that failure to comply with the above Privacy, Confidentiality, and Information Security agreement may result in disciplinary action up to and including denial of access to information and termination of my employment at the University to Washington. I have been given access to all of the UW School of Dentistry Privacy and Information Security Policies:

http://www.dental.washington.edu/compliance/

By signing this Agreement, I understand and agree to abide by the conditions imposed above.

Print Name: _____

Department: _____ SoD Title: _____

Signature: _____ Date: _____

Copy provided on _____ by _____ _____

Date — Name supervisor, manager or designee — Signature

☐ **Provide copy of this Agreement to the faculty, staff or student.** ☐ **File original Agreement in departmental personnel or academic file.**

(All signed Agreements must be maintained for 6 years)

Print Form

Last Revised 1/22/08