Mount Sinai Medical Center

CONFIDENTIALITY STATEMENT

Mount Sinai Medical Center places a high priority on maintaining the confidentiality of its records, documents, agreements, and all other sensitive information. In the course of your duties at the _______________, you may be given access to Confidential Information about patients (including people who choose to participate in our research), employees, students, other individuals, or the institution itself.

By signing this statement, you acknowledge that your access to confidential information is for the purpose of performing your responsibilities at the ___________________ *and for no other purpose.*

1. I will look at and use only the information I need to care for my patients or do my job. I will not look at patient records or seek other *confidential information* that I do not need to perform my job. I understand that in accordance with state and federal law Mount Sinai audits access to protected health information (PHI) to determine whether this rule is followed.

2. I understand that patient information or any other *confidential information* is not to be shared with anyone who does not have an official need to know. I will be especially careful not to share this information with others in casual conversation.

3. I will handle all records-both paper and electronic-with care to prevent unauthorized use or disclosure of *confidential information*. I understand that I am not permitted to remove *confidential information* from my work area. I also understand that I may not copy medical records or remove them from the patient floors or the Medical Records Department unless authorized to do so.

4. Because electronic messages may be intercepted by other people, I will not use e-mail to send individually identifiable PHI to patients unless authorized by those patients. Authorization may be on paper (a statement signed by the patient) or implied (a patient's e-mail request for such information.)

5. If I no longer need *confidential information*, I will dispose of it in a way that ensures that others will not see it in accordance with the______________________and Mount Sinai's Destruction of Confidential Waste policies.

6. If I am involved in research, any research utilizing patient information will be performed in accordance with federal and state regulations and local Institutional Review Board (IRB) policies.

7. If my responsibilities include sharing Mount Sinai's confidential information with outside parties such as ambulance drivers, home care providers, insurance companies, or

research sponsors, I will use only processes and procedures approved by my institution for sharing such information.

8. Any passwords, verification codes, or electronic signature codes assigned to me are equivalent to my personal signature:

   - They are intended for my use only.
   - I will not share them with anyone or let anyone else use them.
   - I will not attempt to learn or use the passwords, verification codes, or electronic signature codes of others.

9. If I find that someone else has been using my passwords or codes, or if I learn that someone else is using passwords or codes improperly, I will immediately notify my manager or Mount Sinai's Compliance Officer. I understand that if I allow another person to use my codes, I will be held accountable.

10. I will handle all *confidential information* stored on a computer or downloaded to diskettes or CDs with care to prevent unauthorized access to, disclosure of, or loss of this information.

11. I understand that the *confidential information* and software I use for my job are not to be used for personal benefit or to benefit another unauthorized institution. I also understand that Mount Sinai may inspect the computers it owns, as well as personal PCs used for work, to ensure that its data and software are used according to its policies and procedures.

I hereby acknowledge that:

I understand the contents of this Confidentiality Statement.

Name (print): Signature: ______________________________

Date:

Preferred Login (if possible):

I work at:

Practitioner's Name(s):

Street: Phone Number:

Apt/Suite:

City: State: Zip:

AND

I work at:

Practitioner's Name(s):

Street: Phone Number:

Apt/Suite:

City: State: Zip:

AND

I work at:

Practitioner's Name(s):

Street: Phone Number:

Apt/Suite:

City: State: Zip:

AND

I work at:

Practitioner's Name(s):

Street: Phone Number:

Apt/Suite:

City: State: Zip:

The Mount Sinai Hospital / Icahn School of Medicine
Acknowledgement of Responsibilities for Faxes

The Mount Sinai Medical Center Department of Pathology will be routinely faxing documents to the office of the _____________________________________in accordance with its past practice or as has been requested. This understanding is based on the facts that the physician(s) at ____ are Covered Entities under HIPAA and that its office manager ensures and attests to the following:

1. A. Its office fax machine phone number is: (____) - ______ - __________
   B. Its office phone number is: (____) - ______ - __________ (for reporting issues with the fax transmissions to the fax machine number sated above)

2. **The above-stated fax machine is in a secure location and that faxes are sent to this fax machine are not left unattended in any area(s) where anyone other than the designated recipient can access these faxed documents.**

3. If its office does not receive an expected faxed document, its office will notify Mt Sinai Pathology immediately using phone number: **(212) 241-7373.**

4. The Office will notify Icahn School of Medicine's Pathology Department immediately of any change in its fax number and, regardless, will verify annually that the fax number on file in the Pathology system is correct.

5. Faxed information will not be re-disclosed without proper authorization or regulatory requirement.

6. The office will notify Mt Sinai immediately using the above phone number if its office receives faxed documents which were not intended to be faxed to its office.

The office of ____agrees with the above statements and understands that it is its responsibility to maintain the confidentiality of any patient reports/documents that are faxed to its office from The Mount Sinai Hospital or the Icahn School of Medicine at Mount Sinai. It will, therefore, put in place such policies and procedures necessary to ensure that facsimile transmitted documents are received and processed in a secure environment.

Office Manager: ______________________________/_______________________
(Printed Name) (Signature)

Date: __________________ NPI: ______________________

Witnessed By: ____________________________ Signature: _____________________
(Print Name)

Date: __________________

Please email completed from to pathologyLIS@mountsinai.org.