Confidentiality and Non-Disclosure Agreement for Physicians

I acknowledge, by my signature below, that I understand that patient medical records, financial information and data to which I have knowledge and access, are to be kept confidential.

Additionally, in performing my duties as a Clinical Trainee at Inova Health System (IHS), I understand that I may come in contact with, or be provided with, confidential or proprietary information. Therefore, I hereby agree that I will not now or at any time in the future, without the prior written consent of IHS either directly or indirectly divulge, disclose, or communicate in any manner whatsoever to any person not employed or affiliated with IHS: (a) any confidential information of IHS obtained pursuant to this Agreement, including patient information and information regarding quality assurance, risk management, and peer review activities obtained pursuant to this Agreement; and (b) any information concerning confidential matters obtained pursuant to this Agreement affecting or relating to the business or operations or future plans of IHS, including, but not limited to, IHS's policies, procedures, rules, regulations, and protocols. I understand that this prohibition applies to divulging the confidential information described above for the purpose of acting as an expert witness, reviewer, or consultant on behalf of a plaintiff or an attorney acting on behalf of a plaintiff, in a claim or action against IHS or any of its affiliates. This shall not prohibit or restrict the divulgence, disclosure, or communication made pursuant to an order of a court of competent jurisdiction, or to sworn affidavits, depositions, or other testimony, or otherwise required by law, required in connection with the defense of any claim or action against IHS. I further agree that in the event I breach this confidentiality requirement, and without limiting the right of IHS to seek any other remedy or relief to which it may be entitled under law, I consent to injunctive relief in favor of IHS.

All Inova Health System printed documents and or materials accessed remotely must be maintained confidential and by my signature on this form, I agree to comply with the IHS policies and procedures regarding disposal of printed confidential information.

I certify that I have been trained on the privacy and protection of patient information, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated there under, including the Security and Privacy Rules. Failure to abide to these standards and regulations may result in termination of my participation in the clinical experience.

I accept full responsibility for any use of my USER ID and PASSWORD.

I understand in the event that a SecureID Fob is issued to me it may be used only by me. I also understand that I may not allow anyone to use my SecureID Fob. I agree that I or my designee will notify the Inova Customer Support Line immediately in the event that the SecureID Fob is lost or stolen.

I declare that I have read and understand the Acknowledgement. I recognize that my breach of this agreement may cause irreparable injury to Inova Health System, and/or the patients and that appropriate disciplinary action may be taken.

Physician's Legal Name: _____
(PLEASE PRINT CLEARLY) FIRST NAME MI LAST NAME

Physician's Signature: _____ Date: _____

E-mail address: _____