Information Services Department
Detroit Medical Center / Wayne State University

CONFIDENTIALITY OF INFORMATION STATEMENT

NON-DMC EMPLOYEES ONLY

This document must be signed by all **Non-DMC employees** prior to being assigned duties or a computer access code or password authorization, unless the company which employs the individual has signed an entity-wide confidentiality statement. In the sole discretion of the Detroit Medical Center ("DMC"), any individual providing services to the DMC may be required to read and sign this statement individually. **No alterations to this statement are allowed.**

As an individual providing services to, on behalf of, or for the benefit of the DMC or any parent, subsidiary, affiliate or successor thereof, I understand that information to which I have access in the performance of my duties is confidential. This duty of confidentiality applies to both individuals and entities. I understand that patient medical information belongs to the patient and that I am only permitted to access patient medical information to the extent that it is necessary to provide patient care or perform my duties. I also understand that all medical and personal information regarding patients is confidential and unless directly related to the care of patients and authorized by DMC policy, should not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside the Detroit Medical Center healthcare environment.

I also understand that other information regarding the operations of the DMC is confidential. This includes any information regarding employees, financial operations, quality assurance, utilization review, risk management, research, procurement, contracting and credentialing of staff. I understand that I am only authorized to access this information if it is required for me to perform my duties. This information should not be revealed or discussed with others within or outside the DMC except to the extent that this discussion is necessary to perform my duties.

I also understand that I may not view my own medical record without the proper authorization. I shall not electronically access my own medical records, or that of my family members, including lab or test results, except as a legitimate function of my job duties or with proper authorization.

I understand that I am required to protect any DMC patient or operations information from loss, misuse, unauthorized access, or unauthorized modification, and to report any suspected breach of security policies.

I understand that I may be given access codes or passwords to DMC computer systems. I will safeguard the security codes and passwords given me. I acknowledge that I am strictly prohibited from disclosing my security codes to anyone including my family, friends, fellow workers, supervisors, and subordinates for any reason.

I understand that I may use my access security codes to perform my duties only. I agree that I will not use anyone else's security codes to obtain access to any computer systems. I understand that I will be held accountable for all work performed or changes made to the system or databases under my security codes and that I am not to allow anyone else to access the computer using my security codes, or leave my computer unattended and permit anyone else to access the system through my computer password.

I understand that failure to follow the confidentiality of information statement is cause for termination of employment, revocation of privileges, or revocation of access to the DMC, and may be noted in my student or personal record, and may result in notice to my educational institution or my agency or employer, if such a relationship exists.

_____	_____	_____
Signature	***Date***	***List all User IDs used***

This form is to be completed and faxed to ISD Security only if you are requesting manager approved access to a DMC Computer System. (THIS SECTION IS REQUIRED FOR SYSTEM/NETWORK ACCESS.)

EMPLOYEE VERIFICATION DATA – *Please complete all of the following:*

Please PRINT legibly: First, Middle, and Last Name (Full Legal Name please)

Department Name:	**Name of Hospital/Site Division:**
Last 4-digits of Social Security Number:	**Date of Birth:**
Your Mother's Maiden Name:	**Work Phone Number:**
The first school you attended:	**Phone Number (other):**
Your favorite animal/pet:	**Pager Number (if applicable):**

ALL PAGES MUST BE SINGLE SIDED. Fax completed forms to ISD Security at 313-578-3449. *Form Updated on 3/21/05.*