CONFIDENTIALITY AGREEMENT

As an employee of Cabell Huntington Hospital, Inc. ("the Hospital"), I may have access to protected health information ("PHI") for treatment, payment or healthcare operation purposes as those terms are defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as well as confidential and proprietary information about the Hospital and its business transactions and relationships.

As a condition of this access, I agree to the following terms and conditions, and acknowledge that violation of any of them shall be grounds for (i) loss of access; (ii) where applicable, disciplinary action up to and including termination of employment in accordance with the Hospital's disciplinary policy; and (iii) where applicable, such actions that may be taken by the Office for Civil Rights, U.S. Department of Health and Human Services, in response to a complaint about a violation of HIPAA:

1. I shall keep confidential all PHI, regardless of whether it is oral, written or maintained in electronic media, and I shall use or disclose such PHI only as permitted by HIPAA or other applicable federal, state or local laws, rules or regulations. I shall also keep confidential all confidential and proprietary information about the Hospital and its business transactions and relationships.

2. I understand that my access to PHI at the Hospital shall be monitored, and I shall be held responsible for all attempts at access using my password regardless of who is actually attempting such access. Therefore, I shall safeguard my password at all times and not share it with any other individuals for any purpose or reason. Likewise, I shall not use another person's password to access PHI. I also shall log off of any Hospital system that contains or provides access to PHI as soon as I am finished using such system, in order to prevent unauthorized access.

3. I understand that I may have access to PHI beyond what I need to carry out my specific job duties and responsibilities. I acknowledge that the fact that I may have access to such PHI does not authorize me to access such PHI in the absence of a legitimate reason to do so. Therefore, I shall limit access to PHI to what is specifically necessary to carry out my specific job duties and responsibilities.

4. I understand that access to PHI of Hospital employees as well as friends and family members is subject to the same use and disclosure requirements as access to any other patient's PHI. Therefore, I shall not access PHI of Hospital employees, friends or family members beyond what is specifically necessary to carry out my job duties and responsibilities.

5. I shall report any of the following to the Hospital's Privacy Officer immediately at (304) 399-2997 or privacyofficer@chhi.org:

   a. If my password is used by another person for access to PHI.
   b. If I become aware of any unauthorized use or disclosure of PHI.
   c. If I ever find that I have accessed PHI in error.
   d. If I am advised by a patient or family member of a potential unauthorized use or disclosure of PHI.

6. I understand that my duties and responsibilities to maintain the confidentiality of information as described in this Confidentiality Agreement shall remain in effect even after my employment at the Hospital ceases.

COMPLIANCE PROGRAM STATEMENT OF UNDERSTANDING

I hereby certify to the following:

1. I have received, read and understand the Hospital's Standards of Conduct and agree to abide by them during the term of my employment.

2. I have been given an opportunity to ask questions about the Standards of Conduct.

3. I have NOT been convicted of a criminal offense related to healthcare nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded healthcare programs.

4. I am NOT aware of any additional circumstances that could represent a potential violation of the Corporate Compliance Program or the Standards of Conduct.

5. I have a duty to report any alleged or suspected violations of the Standards of Conduct in good faith to my supervisor, Human Resources, the Corporate Compliance Contact Person, the Corporate Compliance Officer, or I may contact the Hospital's Corporate Compliance Hotline at 1-800-826-6762.

I agree to comply with all applicable laws, regulations, program requirements and standards of ethical conduct as set forth in the Standards of Conduct.

I understand that any violation of the Confidentiality Agreement, the Standards of Conduct, or any HIPAA or corporate compliance policy or procedure is grounds for disciplinary action, up to and including termination.

Please check the appropriate line:

_____ I certify that this is my first review of the Standards of Conduct and Confidentiality Agreement.

_____ I certify that this is my annual review of the Standards of Conduct and Confidentiality Agreement.

Signature: _____ Date: _____

Print Name: _____

PES 7-27-07