Rev. 3/8/2007

UW Medicine
COMPLIANCE

UW Medicine
VENDOR CONFIDENTIALITY AGREEMENT

A. VENDOR INFORMATION (to be completed by Vendor representative)

Name ("Vendor") _____

Company _____

Address _____

City, State, ZIP _____

Phone number _____ **Fax:** _____

Email _____

Select applicable box:

1. ☐ I will be visiting clinical areas to provide equipment or product or information for a clinical area.
2. ☐ I will be visiting clinical areas and need to use and/or disclose Protected Health Information (PHI) of UW Medicine patients. I confirm that a Business Associate Privacy Agreement ("Agreement") has been signed between my Company and a UW Medicine Entity and I shall only use and/or disclose PHI only as provided for within that agreement.
3. ☐ I will be visiting clinical areas but will not need to use and/or disclose PHI of UW Medicine patients. Any encounter with PHI will be incidental.

B. Vendor Confidentiality Acknowledgement

UW Medicine has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When visiting clinical areas at UW Medicine, Vendor will or may see patients with a variety of medical issues and/or Vendor may see and hear confidential information relating to these patients. This information relates to past, present and future health care.

As a condition of accessing UW Medicine premises, Vendor understands and agrees that:

- Vendor must maintain and safeguard the confidentiality of any and all UW Medicine protected health information.
- Vendor shall not access, use or disclose protected health information, for any purpose other than treatment, unless a Business Associate Privacy Agreement has been signed between the Vendor's Company and a UW Medicine Entity or as otherwise permitted by federal and Washington State law. Vendor will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- Any authorized access to protected health information may be monitored to assure appropriate compliance with system integrity and UW Medicine policies and procedures.
- Failure to comply with the above confidentiality guidelines, or in the event of a breach of patient confidentiality, this agreement and any existing agreements may be terminated and Vendor's ability to participate in future activities at UW Medicine may be denied.

_____ _____

Signature of Vendor Representative ("Vendor") **Date**

C. Agreement to be retained by UW Medicine Department: _____

I understand that I will be responsible for this Vendor when they are accessing clinical areas. If the Vendor must use PHI for

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purposes other than treatment (i.e. if Section A.2 above is checked), I confirm that a Business Associate Privacy Agreement is in place.

Department Manager: _____Signature_____

Phone number: _____ Date: _____