UNIVERSITY HEALTH
CONFIDENTIALITY AGREEMENT

I, the undersigned, hereby acknowledge receipt of a userid and password giving me access to the Hospital Information System of University Health, Bexar County, Texas (hereafter referred to as the University Health) computer system. I understand and acknowledge that this userid and password combination is unique to me and is the electronic equivalent of my signature, with no difference in liability existing between my written and electronic signatures.

I further understand that this userid and password May give me access to confidential patient health care and financial information, employee personnel information, physician information, and business information relating to the University Health (herein referred to as Information), and that the University Health regards maintaining the confidentiality of this information to be of paramount importance.

Therefore, in consideration of the foregoing, I agree to the following:

1. **Information to be confidential**. All Information obtained by me, or on my behalf, whether by me, my office staff, agents, employees or any other person whatsoever, will be maintained in confidence by me, or by any other person acting on my behalf. I further agree that Information will be obtained and used only as necessary to perform my professional responsibilities.

2. **Scope of Information**. I agree that I will use the userid and password only to obtain access to that Information necessary for me to perform my Professional responsibilities.

3. **Use of Userid, Password and Signature Stamp**. I will not disclose my userid and password to any person or entity, nor will I attempt to learn or use any other person's userid and password. I will not share my Signature Stamp with any person.

4. **Issuance of New Userid and Password**. If I have any reason to believe that the confidentiality of my userid and password has been compromised, I will notify the Data Security Administrator immediately so that the suspect userid and password may be deleted and a new userid and password assigned to me.

5. **Responsibility for Self**. I recognize that I am responsible for all actions performed at a workstation activated with my userid and password; therefore, I will terminate the session before leaving the workstation.

6. **Responsibility for Others**. If applicable, I hereby specifically accept responsibility for ensuring that my office staff, agents, employees, or any other person acting on my behalf, in connection with Information, will abide by the terms and conditions of this Confidentiality Agreement.

7. **Violation of Conditions**. I recognize that violation of any of these conditions may result in withdrawal of computer access, termination of employment for employees, denial of hospital access for non-employees, and other disciplinary actions.

8. **Indemnification**. I agree to indemnify and hold University Health harmless from any and all liability, loss, or damage, including attorney's fees, that University Health may suffer as a result of claims, demands, costs, or judgements against it arising from the breach or violation of any provisions of this Agreement by me and/or my staff, agents, employees, or any other person acting on my behalf. I further agree to notify University Health in writing, within ten (10) days by registered U.S. Mail, of any claim made against me or my office staff, employees, and/or agents, on the obligations indemnified against herein.

IN WITNESS WHEREOF, I have executed this agreement at San Antonio, Texas, this _____ day of _____, 2026.

HOSPITAL INFORMATION SYSTEM USER (Student)

PRINT: _____

SIGNATURE: _____

WITNESS

PRINT: _____

SIGNATURE: _____