CLARK MEMORIAL HEALTH

Norton Healthcare and LifePoint Health

Physician Access Authorization Request Form

Clinician Name:	Group Name:
Contact Number:	Email Address:
Indiana License #:	Mother's Maiden Name:

I am requesting access to the following systems for use in patient care. Place an 'X' in the left hand column to indicate which system(s) access is being requested.

X	Application		Date Added	Work Order # Date	Comments
	Network/AD account				
	Sovera Imaging Sys				
	Transcription				
	Radiology PACS&RIS				
	Clark Valet				
	Xcelera (Echo)				
	SAC				

By signing this form you are agreeing to the following statements:

1.) I have read and understand the CMH HIPAA Privacy and Security Agreement and will comply with the policy.

2.) I understand that my network and system activity can be logged and monitored for inappropriate use. Any documentation generated as result of auditing these logs will be turned over to Hospital administration.

Clinician Signature: _____ Date: _____

(If applicant is Allied Health, the Sponsoring MD must sign below).

MD Signature: _____ IN Lic # _____ Date: _____

Medical Staff Services:	Status	Comments
Clinician is in good standing at CMH? ☐ Yes ☐ No Signature and Date	☐ Active Staff Member ☐ Affiliate Staff Member ☐ Associate Staff Member ☐ Allied Health ☐ Courtesy ☐ Nurse Practitioner ☐ Physician Assistant	
Information Systems:	**Documentation**	**Comments**
Date form Received: Date access finalized:	☐ Pri/Sec Agreement Signed	

Revised: October 4, 2018

Name:_____

Please Print

Clark Memorial Health
HIPAA Privacy and Security Agreement
Medical Staff / Employees of Medical Staff

CMH considers maintaining the security and confidentiality of protected health information a matter of its highest priority. All those granted access to this information must agree to the standards set forth in this computer and information usage agreement. All those who cannot agree to these terms will be denied access to protected health information entrusted by our patients to this organization. Each person accessing CMH data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. The following conditions apply to all those having access to protected health information and shall survive the termination of your staff privileges or employment/relationship with related medical practice.

As a Medical Staff Member or employee of a Medical Staff Member and/or group practice:

1. I understand that I am responsible for complying with the CMH policies based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. I will treat all information received in the course of my employment, including but not limited to the patients of CMH, as confidential and privileged information.
3. Upon cessation of my staff privileges or employment with related medical practice, I agree to continue to maintain the confidentiality of any information I learned while on CMH medical staff or as an employee of CMH medical staff .
4. I will respect the privacy and rules governing the use of any information accessible through the computer system/network and only access and/or utilize protected health information that I have a need to know in order to perform my job.
5. I will respect the confidentiality of any reports or documents printed from any information system containing patient/member information and handle, store and dispose of material appropriately.
6. I will not disclose information regarding the patients of CMH to any person or entity other than as necessary to perform my job and as permitted under the organization's policies. I understand that the information accessed through all CMH information systems contains sensitive and confidential patient care, business, financial and hospital employee information which should only be disclosed to those authorized to receive it.
7. I will not use or disclose any information that identifies a patient except that which is allowed by CMH policies based on HIPAA regulations.
8. I will prevent unauthorized use or viewing of any information in files maintained, stored or processed by CMH.
9. I will not remove any worksheet, record, report or copy of such from the area or office where it is kept except in the performance of my duties. I will report any violation of this code.
10. I will not seek personal benefit or permit others to benefit personally from any confidential information or use of equipment available through my work assignment.
11. I will not log on to any CMH computer systems that currently exist or may exist in the future using a logon and password other than my own.
12. I will safeguard my computer password and will not post it in a public place, e.g., the computer monitor, or a place where it will be easily lost, e.g., on my nametag.
13. I will not allow anyone, including other employees, to use my password and/or authentication device to log on to the computer or alter information under my identity.
14. I will not utilize anyone else's password and/or authentication device in order to access any CMH system.

15. I will log off of the computer as soon as I have finished using it.
16. I will not attempt to establish electronic communication to the CMH network except by approved methods.
17. I will use an approved cover sheet for all faxes containing protected health information.
18. I will not use E-mail to transmit a patient's protected health information unless instructed to do so by my departmental management.
19. I will ensure all electronic storage media (CD, DVD, floppy diskette, computer hard drive, etc.) containing protected health information is destroyed according to CMH policy.
20. I will respect the ownership of proprietary software. I will not make unauthorized copies of such software even when the software is not physically protected against copying.
21. I will respect the procedures established to manage the use of all systems.
22. I understand that all access to the system will be monitored.

I understand that my access to protected health information maintained by CMH is a privilege and not a right afforded to me. By signing this agreement, I agree to protect the security of this information and maintain all protected health information in a manner consistent with the requirements outlined under the federal privacy regulations. Any breach of the terms outlined in this agreement will subject me to penalties, including disciplinary action, under CMH policies as well as any applicable State and Federal law. By signing this agreement, I agree that I have read, understand and will comply with all the conditions outlined in this agreement

_____ _____

Signature Print Name

Date:_____ Drivers Lic #:_____

I shall appropriately instruct and supervise the residents, fellows and office staff associated with my practice in the proper access and use of Protected Health Information (PHI). I shall also instruct them that any breach of confidentiality of PHI could lead to their termination and/or termination of access to applications here at Clark Memorial Hospital. I shall immediately notify the Clark Memorial Hospital IS Department at 812-283-2252 upon the termination of residents, fellows, or office staff having signons to CMH applications so their accounts and system access can be turned off

Authorized by: _____, MD Print Name: _____,MD
(required for all requests)

Date: _____