WMC Health | HealthAlliance
Westchester Medical Center Health Network

ELECTRONIC PROTECTED HEALTH INFORMATION ACCESS REQUEST FORM FOR THIRD PARTY USERS

REQUESTING MANAGER	USER
NAME:	NAME:
TITLE:	TITLE:
PHONE:	PHONE:
FAX:	FAX:
EMAIL:	EMAIL:

PROVIDER GROUP OR COMPANY NAME:
ADDRESS:

I am requesting access to the following applications (check all that apply):

- ☐ Paragon
- ☐ EDIMS
- ☐ AMI
- ☐ Cipher/Orchid
- ☐ HEV
- ☐ E-Mail
- ☐ Kronos
- ☐ Midas
- ☐ PACS
- ☐ PeriCalm
- ☐ Other:_____
  _____

Please provide the name of someone who has the same access being requested for the new user:

_____

Start date: _____ End date: _____
Will be set at 6 months if unknown or not listed

****** IMPORTANT: HIPAA RELATED PRIVACY *****

Health institutions must limit the PHI (Protected Health Information) used or disclosed to the minimum necessary to achieve the purpose of the use or disclosure.

By making this request for computer access, you are certifying that the person's access you've requested via their menu provides this minimum standard and is role based.

The Privacy Rule governs PHI. PHI is any information that is: created or received by a covered entity; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual and which: identifies the individual; or offers a reasonable basis for identification of the individual

By signing this form, you certify that you are an authorized manager or supervisor.

Requesting Manager: _____ Date: _____

User: _____ Date: _____

Please e-mail all completed forms to Help.Desk@hahv.org or fax it to (845) 334-4831.

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PROTECTED INFORMATION SECURITY & CONFIDENTIALTY AGREEMENT

☐ **Employee** ☐ **Volunteer** ☐ **Intern** ☐ **Contractor** ☐ **Physician** ☐ **Other: Phys. Office /Other Provider Staff**

Organizational information of HealthAlliance (HAHV) that may include, but is not limited to, financial, patient identifiable, employee identifiable, financial, contractual, and from any source or in any form (i.e. paper, magnetic, optical media, conversations, film, etc.) is considered confidential. The value and sensitivity of information is protected by federal and state law as well as by the policies of HAHV. The intent of these laws and policies is to assure that confidential information will remain confidential through its use, only as a necessity to accomplish the mission of HAHV.

I understand and agree that in the performance of my duties, I must hold patient's personal and medical information in confidence. I agree to consider as confidential, all information which I may hear directly or indirectly concerning HAHV patients, residents, physicians, other professional staff, employees, volunteers, and will not seek confidential information in regard to the same. Further I understand that intentional or voluntary violation of this policy may result in immediate dismissal or termination of access to the HAHV computer systems without notice.

The following conditions apply to all individuals with access to the HAHV information systems including but not limited to employees, students, contractors, temporary staff, consultants, outsourcing firms and other provider staff members.

I will:

- Respect the privacy and rules governing the use of any information accessible through the computer system or network of HAHV, and only access information necessary for the performance of my job responsibilities.
- Respect the ownership of proprietary software. For example, I will not make unauthorized copies of such software for my own use even when the software is not physically protected against copying.
- Respect the finite capability of the systems, and limit my use so as not to interfere unreasonably with the activity of other users.
- Prevent unauthorized use of any information in files maintained, stored, or processed by HAHV.
- Not seek personal benefit or permit others to benefit personally by any confidential information available through my access to the HAHV information systems.
- Not exhibit or divulge the contents of any record or report except to fulfill a work assignment.
- Understand that the information accessed through HAHV Information Systems contains sensitive and confidential patient care, financial, and hospital employee information that cannot be used or disclosed in a manner that violates federal and state privacy regulations.
- Not release my authentication code or device to anyone else, or allow anyone else to access information under my identity.
- Notify my supervisor immediately and the Information Services Help Desk at extension 2800 if I suspect that my user access has been compromised in any way.
- Not utilize anyone else's authentication code or device in order to access HAHV Information Systems.
- Respect the confidentiality of any reports printed from any HAHV Information System containing confidential information; and handle, store, and dispose of these reports appropriately.
- Not divulge any information that identifies a patient except for treatment and payment purposes.
- Follow all policies and procedures in place or that may be developed to protect hospital and patient information, including encryption of emails and personal devices.
- Understand that all access to HAHV Information Systems will be monitored.

If a party to this agreement uses an intermediary third party to transmit, log, or process data, that party shall, prior to the disclosure of the data, obtain an agreement from that third party providing substantially the same protection for the data as this agreement and shall be responsible for any acts, failures, or omissions by that third party in its provision of services. For purposes of this agreement, the third party shall be deemed to be an agent of that party. Upon request, due to termination of the business, relationship, or otherwise, HAHV may request any and all information be returned to HAHV in a form acceptable to HAHV and that no copies may be retained by the party.

I understand that my access to protected information maintained by HAHV 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 information in a manner consistent with the requirements outlined in the *Confidential Information Policy* as well as under HIPAA and all state and federal privacy regulations. I understand that **any breach of patient confidentiality will subject me to civil and criminal penalties as mandated by state and federal regulations.**

I further understand that any unauthorized use of HAHV Information Systems and any breach of the terms outlined in this agreement may be considered cause for immediate disciplinary action, up to and including, termination of employment or access to the HAHV information systems. By my signature below, I agree that I have read, understand, and will comply with all the conditions outlined in this agreement. I affirm that there is no reason whatsoever that I should not be trusted with accessing, using and disclosing patient information for permitted purposes.

_____ _____

Employee Signature *Date*

_____ _____ _____

PRINT Employee Name *Title* *Contact Phone #*

Physician Practice/Provider Name _____ *Email* _____