INSTRUCTIONS ON CONFIDENTIALITY FORMS:
Complete all four (4) and fax to 949-764-4203

Attachment A

Provider: Physicians name and/or group name
Effective Date: Today's date

Last Name: Physicians last name(s)
First Name: Physicians first name(s)
Physician Specialty: Gynecologist, Neuro, etc.
HH Medical Staff ID Number: Hoag Hospital staff number
Email Address: Physician email address(es)

Print Name: Physician and/or Office Manager name
Signature: Physician and/or Office Manager Signature
Email Address: Physician and/or Office Manager Email

Attachment B.2 (CAF)

Account Status Information:

- **Date of Request**: Today's date
- **Physician Name/Group/Joint Venture**: Physician or group name
- **Phone Number:** Physician and/or group phone number
- **Fax Number:** Physician and/or group fax number

Individual Physician Employee Account Information:

- **Add**: Check add
- **Delete**: Leave blank
- **Last Name**: Scheduler last name
- **First Name**: Scheduler first name
- **Middle Initial**: Scheduler middle initial
- **Last 4 Digits SSN**: Scheduler last 4 of SSN

Computer Access Requirements:

- **Remote (external) VDI access**: Check add
- **SCM (Allscripts)**: Check add

Security Authorizer Approval:

- **Signature**: Physician and/or Office Manager Signature
- **Email**: Physician and/or Office Manager Signature
- **Date:** Today's date

HOAG MEMORIAL HOSPITAL PRESBYTERIAN
CONFIDENTIALITY AND SYSTEM ACCESS AGREEMENT

The purpose of this agreement is to outline your responsibilities related to accessing Protected Health Information ("PHI") (as defined at 45 C.F.R. § 160.103) through the Hoag Memorial Hospital Presbyterian ("Hoag") electronic health record system ("Hoag's System").

All information available through Hoag's System is confidential and shall be treated as such. Related to accessing PHI through Hoag's System, I agree to the following:

1. I acknowledge that Hoag's System is the property of Hoag, and I agree to use Hoag's System for job-related purposes only. In using Hoag's System, I will comply with the Health Insurance Portability and Accountability Act of 1996, and the implementation regulations thereunder, as well as relevant state law.

2. I will only access the minimum amount of PHI through Hoag's System that I need to do my job on behalf of the entity listed below ("Entity"), and only from my designated work station at Entity. Unauthorized access or attempted unauthorized access of PHI by me is a violation of this agreement whether or not such information is further used or disclosed in any manner. I understand that accessing my, my family's or my friend's health information through Hoag's System is inappropriate unless my job requires me to do so, and that I may not access any PHI through Hoag's System out of personal curiosity or for personal gain.

3. I will not share any PHI with anyone outside of my job responsibilities at any time, even if I am no longer affiliated with Entity.

4. I will neither download nor transmit in any manner PHI from Hoag's System for the purpose of storing such information on computer hardware or removable media unless such activity is required by my job and appropriate safeguards are in place.

5. I will keep any and all of my user IDs and passwords necessary to access Hoag's System secret and I will not share them with anyone, nor will I use anyone else's password(s) to access Hoag's System. I am responsible for any access to Hoag's System gained by using my user ID, including damages for the inappropriate use or disclosure of PHI using my user ID. If I suspect that my password or user ID have been obtained by another individual, I agree to immediately inform Hoag's Privacy Officer so that appropriate action may be taken. I will log out of computer programs appropriately to minimize possible unauthorized access to PHI through Hoag's Systems.

6. I understand that Hoag's System is monitored by Hoag and that Hoag is able to track and monitor my access to Hoag's System. I understand that I do not have personal privacy rights related to my utilization of Hoag's System. I agree to cooperate with any audit or investigations by Hoag related to my use of Hoag's System.

7. I agree to use only an encrypted email account when communicating access and security information with Hoag.

8. I understand that should I fail to comply with the requirements of this agreement, Hoag will discontinue my access to Hoag's System. Additionally, should I fail to comply with this agreement, I understand that I may be subject to civil and criminal liability and that Hoag may take legal action against me.

9. I agree to indemnify, defend, and hold harmless, Hoag and its affiliates, and their respective members, trustees, officers, directors, employees, and agents, from and against any claim, cause of action, liability, damage, cost or expense, including without limitation reasonable attorneys' fees and costs arising out of or in connection with any unauthorized or prohibited use of Hoag's System by me, or any other breach of this agreement.

By signing this agreement, I acknowledge that I have read and understand my responsibilities regarding access to Hoag's System.

______________________ Print Employee Full Name	______________________ Physician Provider/Group Name ("Entity")
______________________ Signature of Employee	______________________ Date Signed

Hoag Memorial Hospital Presbyterian

ATTACHMENT A
PHYSICIAN/PHYSICIAN GROUP/JOINT VENTURE

Provider consists of the individual providers listed below. If an individual provider joins Provider, the individual can be added to the Agreement by re-submitting Attachment A with a revised effective date.

Provider: ______________________

Effective Date: __________________

Last Name	First Name	Physician Specialty	Hoag Hospital Medical Staff ID Number [For Provider Personnel who are Medical Staff members]	Email Address [Required for employee validation process. This address must be secured and encrypted.]

Provider's designated Security Administrator to notify Hoag of terminations, additions and password resets.

Print Name	Signature	Email Address

Hoag Memorial Hospital Presbyterian
Attachment B.2
Computer Access Form (CAF)
MEDICAL STAFF EMPLOYEE

Instructions: Access to, or termination of system access and/or user password reset can only be authorized by the Security Authorizer or the Provider's Primary Contact as defined in the *Access and Authorization Agreement.* Once completed, this Agreement, along with the *Confidentiality and System Access Agreement* and this CAF must be faxed to the Hoag Hospital IT Service Desk at 949-764-8660. For questions regarding this form please call the IT Service Desk at 949-764-8600.

Please allow 7 business days for the Service Desk to complete the request.

I. ACCOUNT STATUS INFORMATION

Date of Request	Physician Name/Group/Joint Venture	Phone Number	Fax Number

II. INDIVIDUAL PHYSICIAN EMPLOYEE ACCOUNT INFORMATION

Add	Delete	Last Name	First Name	Middle Initial	Last 4 Digits SSN
Business Email Address (if available):					

III. COMPUTER ACCESS REQUIREMENTS

Add	Delete	System Access
		Remote (external) VDI access
		SCM (Allscripts)

IV. SECURITY AUTHORIZER APPROVAL

Signature	
Email	
Date	

NOTE: Upon completion of set-up of user, the Security Authorizer will be notified via secured email or US Mail.

V. Hoag Hospital IT Access Set-Up – Hoag Use Only

	Remote VDI / SCM
Employee Login Name:	
Temporary Password:	
Usergroup Name:	
Effective Date:	
Set-Up Completed By:	

Acknowledgement of Receipt of Security Agreement

This is to acknowledge I have received a copy of *the Hoag Security Agreement*. I understand this document contains important information about Hoag Hospital's general security policies, compliance program, code of conduct and my privileges and obligations as a system user.
As a user acting on behalf of my physician, it is understood that either Hoag Hospital, the physician I am working for, or I can terminate access to the Electronic Medical Record (EMR) systems at any time, without notice.
I will familiarize myself with the material in the agreement and I understand I am governed by its contents. I understand that I have the responsibility to report any activities that may not be in accordance with the law or Hoag's compliance program. Also, I agree to engage in the interactive process. I further understand Hoag Hospital may change, rescind or add to any policies, benefits or practices described in the security agreement, at its sole and absolute discretion with or without prior notice.

Signature	
Date	

Acknowledgement of SCM Training through Computer Based Training Module

Hoag requires all users of its Electronic Medical Records (EMR), Sunrise Clinical Manager (SCM) to sign and acknowledgment confirming they have received been trained, understand the systems' purpose, will act according to my physician's direction, and will adhere to policies of the hospital and agree to abide by it. New SCM users are required to sign this acknowledgment as a condition of system access and utilization. Signed originals will be maintained in the hospital's Security Department. Each system user is also required to participate in compliance training, as directed. Adherence to and support of the Security and Compliance guidelines and participation in related activities and training is considered in decisions regarding ongoing system utilization.

"This is to acknowledge I have read and understand these policies completely and I further acknowledge that I am required to adhere to these policies at all times during the course of my work." I also understand that I am required to report any violations of the Security Policy to the appropriate management representative, Human Resources, or Corporate Compliance Department or Compliance Line of Hoag Hospital (1-800-441-1727).
I understand that any access given will be revoked & must be reported to the Service Desk, by calling (1-949-764-8600) upon a change in employment.

Signature	
Print Name	
Requesting Physician(s) Name(s), & Med Staff Number(s)	
Physician Signature(s)	
Date	
Office Address	
Office Phone Number	