



Information Services Remote Access Agreement for Physician Practices

This is the application for a login ID and password to access WakeMed information systems remotely. Please fax the completed form to: 919-350-2589. Please contact Medical Staff Services at (919) 350-2671 about your fax. Please contact Physician Relations at (919) 350-5911 or the Help Desk at (919) 350-8700 with any questions.

Please Print:

First Name _____ Middle _____ Last _____ Maiden _____

Title _____ Last 5 digits of SSN# _____ Date of Birth _____

Physician/Group Name _____

Street _____

Street 2/Suite _____

City _____ State _____ Zip _____

Phone# _____ Fax# _____

Non WakeMed RNs, LPNs, Physician Assistants, Nurse Practitioners, Midwives, and other licensed personnel

Medical License # _____ Exp Date: _____ Nursing License # _____ Exp Date _____

NPI or Social Security # _____ Degree: _____

In consideration of this Agreement, WakeMed permits me to access its information systems remotely. I hereby agree as follows.

I hereby acknowledge that I understand that the information and data contained within the WakeMed information systems or other computer files or records are confidential, and that my use of access to WakeMed information systems or other computer files or records is subject to the following requirements. My employer has provided me with education about HIPAA and I agree to abide by those standards.

1. I am only authorized to access those WakeMed information systems, other computer files or records that relate to my current job functions as an employee of the physician practice listed above for the purpose of providing care or billing for services. I also acknowledge that access to these same resources will be limited to my "need to know" for patients who are under the care of physician(s) within the above practice. By accessing a patient's record, I am affirmatively representing to WakeMed at the time of each access that I have the requisite business need to know the content of the particular medical record I am accessing, and WakeMed may rely on that representation in granting such access to me.

2. I am authorized to use only the sign-on or password specifically assigned to me to gain authorized access to these systems, and may not use or attempt to learn any sign-on or password given to others. I will not allow my sign-on and password to be used by any other individual. I will not write down, or otherwise document, my sign-on or password where another individual may potentially view either. I am not authorized to disclose my assigned sign-on or password to anyone, including any of my co-workers, physicians, family members or others, other than to authorized employees of the WakeMed Information Services Department in the event problems are encountered. In the event I have reason to believe that the confidentiality of my sign-on or password or another sign-on or password has been breached, I will contact WakeMed Information Services at (919) 350-8700 immediately to inform them of the breach. To prevent the unauthorized use of my sign-on and password by another user, I will always log off the systems when completed with my work or when leaving the workstation. I will be responsible for any unauthorized access to WakeMed information systems that may occur under my access code and password if I fail to do so.

3. I will not disclose any patient's medical records or any portion thereof, to any person or entity that is not authorized by law to have access to such information. I will respect the confidential nature of the information I access. All printed materials generated from the information systems or other hospital computer systems are confidential information and may only be used for patient care and billing purposes. I will ensure that no patient or other confidential information from WakeMed information systems is downloaded or stored on any non-WakeMed information system except for patient care or billing purposes. I will ensure that any agent, including a subcontractor, to whom information from WakeMed information systems is provided agrees to protect the confidentiality of protected health information.

4. I understand that encryption of patient and other confidential data is an important safeguard to protect this information from unauthorized disclosure and/or access. I shall encrypt all patient and/or other confidential information obtained from WakeMed's information systems when storing this information on any non-WakeMed information system, including any type of portable media (e.g. laptop, portable drive, personal digital assistant, thumb or USB drive, CD, DVD, or other portable electronic storage device).

5. If I suspect that patient and/or other confidential information from WakeMed information systems has been released inappropriately, I will notify the WakeMed Privacy Officer immediately at (919) 350-7580.

6. I understand that any reports or results identified as interim or preliminary or those reports that have not been authenticated by a physician are not intended for use as a final report or final result. I am not authorized to input any data into Information Services or other WakeMed computer files or records. Any exceptions to this will be specified as an amendment to Agreement.

8. I understand that WakeMed may monitor my activity while on WakeMed information systems as WakeMed deems necessary for purposes of maintaining the integrity, confidentiality and effective operation of the WakeMed electronic information systems. Any unauthorized activity may be reported to the legal authorities.

9. I understand that it is my responsibility to follow industry standard security practices, including the prompt application of all software patches and updates, the use and maintenance of anti-virus software, the use of a host-based firewall, and the selection of an alphanumeric password including at least one number. A resource for industry standard security practices for small and home offices is found at http://www.sans.org/reading_room/whitepapers/hsoffice/.

10. I understand that WakeMed will conduct periodic audits to review activity on WakeMed information systems in order to identify and/or investigate unauthorized access to patient or other confidential information, or other security breaches. I understand I may be required to produce a reason for each access that is audited.

11. I understand that my sign-on and password are the legal equivalent of my signature, and that any unauthorized access to computer files or records using my sign-on and password could violate federal laws and/or the laws of the State of North Carolina. I understand that I am personally responsible for any and all access to WakeMed systems using my sign-on and password.

12. Violations of the above standards, by Practice, its physicians, its employees, or me will constitute a breach of this Agreement and potentially subject me to criminal and civil penalties under the Computer Fraud and Abuse Act (18 USC 1030). I understand that any violation of this Agreement shall entitle Hospital, in its sole discretion, immediately to cancel my access to patient information. If I am a member of one or both of the WakeMed Medical Staff(s), I also understand that violations of patient privacy may result in disciplinary action being taken by the WakeMed Medical Staff(s) and Board of Directors. In addition to the potential revocation of my access or appropriate disciplinary actions, I acknowledge my responsibilities to follow applicable federal and state laws regarding access to said systems from WakeMed.

I hereby acknowledge that I have read the Agreement and I will comply with its terms.

Signatures

Signature of Applicant	Printed Name	Date
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I certify that I am an authorized affiliate for the physician practice listed above and I am requesting access for the Applicant named above under the terms of the Information Services Remote Access Agreement for Physician Practices. I certify that I know this individual has been properly trained in standards of patient privacy and confidentiality as established by HIPAA and is known by me to be responsible in the use of confidential information.

Signature of Authorized Physician Affiliate	Printed Name	Date
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E-mail (required)	Phone (required)
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References:

1. Administrative-Corporate Policy –WakeMed Information Systems Security 12/2007
2. Medical Staff Services Policy –Remote Access
3. Release of Confidential Information from Patients Medical Records
4. Monitoring Access into Electronic Medical Records