Ingham Regional Medical Center

ACCESS AND CONFIDENTIALITY AGREEMENT

Physician Name: _____

"Confidential Information" includes information relating to:

A. Any individuals' **P**rotected **H**ealth **I**nformation (PHI), which is information that identifies an individual (name, social security number, account number, etc.) and is created or received by a health care provider, health plan, or healthcare clearinghouse, is transmitted or maintained in any medium (i.e. electronic medical record, paper, oral), and relates to the past, present or future physical or mental health condition, or payment for the provision of care (including medical records, conversations, admitting information, and patient financial information);

B. Employees (including medical records, compensation, benefits, employment records, and disciplinary actions);

C. McLaren Health Care Corporation's or Ingham Regional Medical Center's specific information (including financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs and technology and source code); and

D. Proprietary third-party information (including computer programs and technology, client or vendor information and source code).

I understand and agree as follows:

1. As a physician member of IRMC's Organized Health Care Arrangement (OHCA), I may learn of or have access to Confidential Information through computer systems (including, but not limited to patient care information systems, other clinical and financial information systems, the longitudinal patient record, and the actuarial and claims systems) or through my employment.

2. I will use Confidential Information/PHI only as minimally necessary to perform my legitimate job duties, as well as safeguard and limit access to any Protected Health Information in *any medium* (including written, oral or electronic formats).

3. I will safeguard access to Confidential Information, or any Confidential Information/PHI.

4. I will protect any and all PHI obtained as physician member of IRMC's OHCA after my privileges at IRMC have ended.

5. I understand that IRMC may routinely monitor and audit access to information regarding, but not limited to, employees and patients, their relatives, public figures, and VIPs for appropriateness of access to such information as it relates to my legitimate duties.

6. If applicable: I will sign off the computer when I leave the computer system.

7. I understand that I am responsible for all activity logged under my password (access to the EMR). I understand that I must log off before another user may use the computer.

8. E-mail system will be used in ways consistent with the IRMC E-Mail, Internet Use and Standards policy.

9. I will notify IRMC immediately if I suspect or learn that my access code, other authorization for access to Confidential Information or any Confidential Information has been misused or disclosed

without proper authorization. I understand the purpose of this notification is to protect confidentiality by having my unique information systems access code(s) changed.

10. IRMC may, at any time, revoke my access code or other authorization for access to Confidential Information.

11. A violation of this Agreement will subject me to discipline, including, if warranted, termination of IRMC records.

12. I understand that violation of my duties as discussed above may independently constitute a violation of applicable criminal/civil laws.

I have received training and understand concepts regarding confidentiality, privacy and security as they relate to the Health Insurance Portability and Accountability Act (HIPAA), and was given the opportunity to ask questions.

Date: _____ Physician Signature: _____