Request # _____
(Provided by OhioHealth IS Support Services

OhioHealth

Confidentiality and Access Agreement for HIPAA Covered Entity or Business Associate Representatives

This statement summarizes the responsibilities and obligations of all persons who use, create, access or receive patient information owned by OhioHealth through one of the following arrangements (check the applicable box and provide the requested name):

☐ On behalf of a **Covered Entity**, as defined by the Health Insurance Portability and Accountability Act ("HIPAA"), such as another health care provider, a payer or plan, for purposes of payment of health care treatment provided to the patient who is the subject of the health information.

Covered Entity's name: _____

☐ On behalf of a **Business Associate**, as defined by HIPAA, who has signed a Business Associate Agreement with OhioHealth and has contracted to provide services to or on behalf of OhioHealth.

Business Associate's Name: _____

The scope of this statement covers all employees, agents, servants, volunteers, trainees, and contractors of the Covered Entity or Business Associate listed above that may access OhioHealth patient information.

I understand and acknowledge that:

- I must use best efforts to protect the privacy, confidentiality, and security of all OhioHealth patient information used, accessed, received and/or created.
- I will use, access, disclose, transmit and store all OhioHealth patient information only in accordance with HIPAA and any applicable Business Associate Agreement, and limited to the minimum information necessary to accomplish Covered Entity's or Business Associate's purpose. I will access OhioHealth patient information only when I am required to do so for specific, authorized business purposes.
- I will not permit any unauthorized person to use, access, receive, examine or make copies of any OhioHealth patient information that comes into my possession.
- Unauthorized disclosure of OhioHealth patient information is totally prohibited.
- Disclosure of or sharing of passwords, access codes, hardware token devices, and any other assigned to me (my "Access Credentials") is prohibited. I am accountable for my Access Credentials and for any improper access to information gained through use of my Access Credentials. My Access Credentials are the equivalent of my legal signature, and I shall take all reasonable and necessary steps to protect my Access Credentials. I am responsible for all actions taken using my Access Credentials. If I have reason to believe that the confidentiality of my Access Credentials has been broken, I shall immediately notify the OhioHealth Security Officer or Privacy Officer at 866-411-6181 or via mycompliancereport.com (Access ID: OHH).
- I will not divulge patient information to unknown sources without proper identification, authorization and confirmation of identity.
- If I violate any of the above statements, OhioHealth has a right to immediately revoke or terminate my Access Credentials.

By signing below, I acknowledge that I have read and understand the foregoing information and I agree to comply with the above terms.

_____ _____
Print: First Name, MI, and Last Name Signature and Date