HAWAII HEALTH INFORMATION CORPORATION
Hawaii's source of healthcare data

INFORMATION & SYSTEMS ACCESS REQUEST FORM

Instructions:

1. Fill in all fields, ALL FIELDS ARE REQUIRED.
   This form has been modified so that you may enter information directly on this form and then print out the completed form for appropriate signatures.
2. Sign and date the attached "Data Use and Agreement"
3. Fax (808-534-0292) or mail the completed form and executed Data Use Agreement with all signatures to Hawaii Health Information Corporation, 733 Bishop St., Makai Tower, Suite 1870, Honolulu, HI, 96813.

Organization:			
Name (Last, First):			
Title:			
Areas of Responsibility:	☐ Safety/Quality ☐ Clinical Services	☐ Marketing/Planning ☐ Operations	☐ Financial Services ☐ Other _____
Mailing Address:			
E-mail:			
Phone Number:			
Fax Number:			
Identifiers: **(Required to reset your access over the phone)**			
Home Zip code:			
Mom's first name:			
SSN (last 4 digits):			
HHIC Approval:			
HHIC Approval:			
	Print Name	**Signature**	**Date**

FOR HHIC'S USE ONLY		
Level of Access (Class):		
☐ HHIC E-mail	☐ VPN	☐ Secure File Transfer
☐ RDP _____	☐ Other _____	☐ Other _____

Date Received:			
Date Entered:			
Date Access Started:		Date Access End:	
Date Approved:		Approved By:	
			Signature

As a condition to receiving a computer sign-on code and allowed access, and/or being granted authorization to access any form of confidential information identified above, I, the undersigned, agree to comply with the following terms and conditions:

- My Sign-On Code is equivalent to my LEGAL SIGNATURE and I will not disclose this code to anyone or allow anyone to access the system using my Sign-On Code.
- I am responsible and accountable for all entries made and all retrievals accessed under my Sign-On Code*,* even if such action was made by someone other than me due to my intentional or negligent act or omission. Any data available to me will be treated as confidential information.
- I will not attempt to learn or use another's Sign-On Code or access any on-line computer system using a Sign-On Code other than my own.
- I will not access or request any information for which I have no responsibility, including personnel, billing or private information.
- If I have reason to believe that the confidentiality of my User Sign-On Code or password has been compromised, I will immediately change my password and notify HHIC's Privacy and Security Officer.
- I will not disclose any confidential information unless required to do so in the official capacity of my employment or contract. I understand that I have no right or ownership interest in any confidential information of HHIC.
- I will not leave a secured computer application unattended while I am signed on.
- I will comply with all policies and procedures and other rules of HHIC relating to confidentiality of information and Sign-On codes.
- I understand that my use of the system will be periodically monitored to ensure compliance with this agreement.
- I agree not to use HHIC information in any way that may be detrimental to the organization and will keep all such information confidential.
- I will not disclose protected health information or other information that is considered proprietary, sensitive, or confidential unless done so for an established need-to-know basis.
- I agree that disclosure of confidential information is prohibited indefinitely, even after termination of employment or business relationship, unless specifically waived in writing by the authorized party. This agreement shall survive the termination of employment or the termination, expiration, or cancellation of any contractual agreements.

I understand that if I violate any of the above terms, I may be subject to disciplinary action, including discharge, suspension, loss of privileges, termination of contract, legal action for monetary damages or injunction, or both, or any other remedy available to HHIC. I further understand that these assurances are collected by Hawaii Health Information Corporation to comply with its confidentiality requirements. My signature indicates my agreement to comply with the above-stated requirements with the knowledge that any violation of this agreement may be subject to civil penalties and litigation. Violators of this agreement may also be subject to penalties under state and federal confidentiality laws that apply to these data.

Signature:	**Date:**
Print or Type Name:	
Title:	
Organization:	

Send Questions & Comments to: info@hhic.org