



**SYSTEMS ACCESS SECURITY AGREEMENT**

I, \_\_\_\_\_ have read, understood, and will comply with the following:  
 (Last name, First name, Middle initial)

- \_\_\_\_\_ I am the only person authorized to use my password(s) and user ID(s).
- \_\_\_\_\_ I will not disclose my password(s) or user ID(s) to anyone.
- \_\_\_\_\_ I will not attempt to learn another person's password(s)/user ID(s).
- \_\_\_\_\_ I will not attempt to access information by using a password(s) or user ID(s) other than my own.
- \_\_\_\_\_ I will retrieve or attempt to retrieve from the computer system only medical data that is directly related to the treatment of patients with whom I have a clinical relationship or those patients for whom I have been asked to provide a consultation or for approved educational or research purposes. I agree to maintain the confidentiality of all such patient data. I will access patient data only as required by my employment or medical staff responsibilities or for approved educational or research purposes.
- \_\_\_\_\_ It is my responsibility to logout of the system. I will not, under any circumstances, leave a computer terminal to which I have logged in unattended.
- \_\_\_\_\_ If I have reason to believe that the confidentiality of any of my password(s)/user ID(s) has been compromised, I will contact the Systems Department immediately so that my password(s)/user ID(s) can be deleted and a new password(s)/user ID(s) assigned to me.
- \_\_\_\_\_ I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to the Medical Information Services manager.
- \_\_\_\_\_ I understand that my password(s)/user ID(s) will be deleted from the system when I am no longer employed or have privileges at this institution or when my job duties do not require access to the medical record database. I will immediately report any such status change to the Systems Department.
- \_\_\_\_\_ I understand my access will be automatically deactivated after 90 days of non-use.
- \_\_\_\_\_ I understand that medical records confidentiality is required by law, and that there are statutes specifically mandating the confidentiality of, among other areas, mental health, HIV, and drug and alcohol-related treatment records.
- \_\_\_\_\_ I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions may result in disciplinary action from termination of access to the system or appropriate medical staff or University disciplinary measures up to and including termination of my employment with the University or the hospital.
- \_\_\_\_\_ I understand that the Systems department maintains an audit trail of accesses to patient information that records the user, date, and patient identification of all accesses to electronic medical records.
- \_\_\_\_\_ I understand that my access rights are subject to periodic review, revision and annual renewal.
- \_\_\_\_\_ I will not attempt to connect any personal laptop, PC, or hand-held devices to the private hospital wired or wireless networks.
- \_\_\_\_\_ I will not attempt to alter any security software, filters, policy, or configuration on any hospital devices.
- \_\_\_\_\_ I will not load, install, or remove any software on a hospital device or on the Common Desktop without assistance or approval from the FMC Systems department. (This includes screensavers and Internet toolbars).
- \_\_\_\_\_ I understand that I am absolutely liable for all activity that takes place under my credentials.
- \_\_\_\_\_ I understand that if I do not accept these restrictions of access I may be denied access or have access terminated to relevant computer systems and networks.

*Please initial all lines above, and complete all fields below; incomplete forms will not be processed*  
**Applicant :**

<p><b>Choose one:</b></p> <input type="checkbox"/> New User Request <input type="checkbox"/> Current User (Renewal)
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Printed Name \_\_\_\_\_

Office/Department/Unit: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**

**Applicant's Supervisor or Office Manager Approving Issuance of this Account:**

Name \_\_\_\_\_ Position \_\_\_\_\_ Telephone Number \_\_\_\_\_

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**

**Fax completed form to FMC Systems Department at # 740-689-6765**