

NON-EMPLOYEE ID REQUEST

WESLEY MEDICAL CENTER

NOTE: A signed Information Security Agreement must be submitted with this form.

Last (print) First MI

Title Social Security Number (all digits required) Date of Birth

Graduation Date Instructor Name

Student Hospital Start Date Student Hospital Stop Date

Office or School Name Phone

Office or School Address Fax

City State Zip

Email Address

Physician Office Staff/Billing Agency check only access(s) needed:

_____ Meditech _____ Radiology PACS _____ QS
_____ Surgery Schedule (inquiry only) _____ CV PACS _____ ACCUCHECK
_____ SecureID (Remote Access SRA) _____ Pyxis

Other / Comments _____

> _____
Physician / Office Manager Signature / Dept Director Date

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I understand that I am being given access to the Wesley Medical Center computing equipment. I agree not to share my User ID and Passwords with any other person. I further understand that I am responsible for any activity performed under my User ID. I understand that violations of this agreement could lead to denial of access to the Wesley Medical Center computer and password.

> _____
Non-Employee Signature Date

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For Use By Security Administrator Only

Provider Number : _____ Provider Dictionary Date: _____ By: _____

3-4 ID: _____ WIS.CHANGES Notified: _____

Security Administrator Date

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Route to: Med. Staff Office (for Provider #) and Information Services (for 3-4 ID)
Forward copy to GME (Fax: 27231) or Staff Development (Fax: 23041)
550 N. Hillside, IT&S Dept., Wichita, KS 67214
Phone: 316-962-7800 Fax: 316-962-7083

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

<ol style="list-style-type: none"> 1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. 2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. 3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used. 4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information. 5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company. 6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company. 7. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with the Company. 8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company. 9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies. 10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals. 11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security. 12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view. 	<ol style="list-style-type: none"> 13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards. 14. I will: <ol style="list-style-type: none"> a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)). b. Use only approved licensed software. c. Use a device with virus protection software. 15. I will never: <ol style="list-style-type: none"> a. Disclose passwords, PINs, or access codes. b. Use tools or techniques to break/exploit security measures. c. Connect to unauthorized networks through the systems or devices. 16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information. <p>The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):</p> <ol style="list-style-type: none"> 17. I will only access software systems to review patient records when I have a business need to know. By accessing a patient's record, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know, and the Company may rely on that representation in granting such access to me. 18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access. 19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
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Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name and COID Wesley Medical Center 31608	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	