Individual User Agreement

CONFIDENTIALITY and USAGE AGREEMENT REGARDING ACCESS TO ELECTRONIC MEDICAL RECORDS

Lexington Medical Center (Hereafter referred to as "Hospital") is committed to protecting the privacy and security of individually identifiable health information and other protected health information (PHI) of a confidential nature for the Hospital. Information pertaining to patients and other sensitive information must be held in strict confidence.

I hereby acknowledge that I have been given access to the Hospital Information System for Lexington Medical Center to view and/or print patient information. The User ID and password will provide access to the patient's Electronic Medical Record, (EMR) which includes demographics, lab, medications, transcription, and imaging information and I understand and agree that this is for my use only and will be in my possession only.

Print Name of Person Receiving Access (First, Middle Initial, Last)	Phone #
Job Title / Employer	Clinic Affiliation (if applicable)
E-mail Account (Needed for tracking request and communicating authorization)	Last 4 Digits of SSN is required (Used for reset verification only)
Employer Address	Date of Birth

Because I have been approved for access to the Hospital's EMR, I understand and agree to the following:

A. I understand that I will be able to access medical records by using an individual identification account (User ID) and password that will be assigned only to me.

B. I will safeguard and will not disclose my User ID, password or any other authorizations I may have that allow me to access PHI. I will accept responsibility for all activities performed under my access codes, passwords or other authorizations.

C. I understand that when an authorized individual's identification account is used to gain access to an EMR, the identification account, time of access, and the name of the patient whose medical record was accessed will be recorded. I understand that my activities and access to the EMR may be monitored and audited.

D. I will not use the access codes and passwords of another individual to access PHI and I will not allow another individual to use my access code and password.

E. I will protect the privacy, confidentiality and security of the PHI accessed from the EMR in accordance with State and Federal privacy regulations.

F. I will comply with the privacy, confidentiality and security policies of the Hospital.

G. I will comply with the privacy, confidentiality and security policies of my own employer or the program with which I am affiliated.

H. I will only access and use the PHI that is reasonably necessary for me to perform the duties required under my EMR access request.

I. I will not in any way divulge, copy, release, sell, loan, alter or destroy any PHI except as properly authorized by the policies of the Hospital.

J. I will not electronically transmit PHI in a manner that is not secure. I agree use appropriate safeguards to prevent use or disclosure of PHI other than as provided by this agreement to prevent PHI form loss, misuse, or unauthorized alteration or destruction. This includes the use of up-to-date antivirus and security patching on all devices used to connect to the EMR.

K. If I enter orders on behalf of a healthcare provider, I agree to provide copies of the order to Lexington Medical Center when requested. I will not submit orders on behalf of a provider without a signed order.

L. If I become aware of any use or disclosure of PHI in violation of this agreement, I agree to promptly (but within no less than 7 days) report any such use or disclosure to Lexington Medical Center Compliance or Risk Management Office. I will provide, to the extent possible, any information required to support breach notification requirements as applicable under 45 C. F. R. § 164.404(c).

M. If my employment is terminated during the course of my access to the EMR or my participation ceases in the program with which I am affiliated, I will notify the Hospital immediately and return all accumulated PHI to my employer or the Hospital directly. I understand that upon termination of my employment or affiliation this Agreement is automatically terminated.

N. I acknowledge that my failure to comply with this Confidentiality Agreement may result in termination of access to the EMR, as well as disciplinary actions imposed by my employer.

O. I understand that any violation of the confidentiality of medical information may result in a violation of State and Federal law including but not limited to, HIPAA (The Health Insurance Accountability and Accountability Act of 1996) and may result in civil or criminal penalties as described by State and Federal law.

P. I understand and agree that any information obtained from the EMR to which I have access is confidential and must not be disclosed to others unless the patient or his/her authorized representative explicitly consents to such disclosure.

Q. I further understand that specific State and Federal requirements regarding protection of alcohol and drug abuse records, mental health records and HIV-related information prohibits me from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

R. I understand that, if my account is inactive for a period of 180 days, the account may be revoked and a new application will be required to reinstate the access.

My signature below signifies that I have read and understand the content and information contained in this Agreement in its entirety and I agree to be contractually bound by the specific terms of this Agreement.

_____ _____

Signature of Person Receiving Access Date

To be completed by Information Systems Department Only:

USER ID: _____ **Temporary Password:** _____

COMPLETED BY / Date: _____