

**CONFIDENTIALITY AND USE AGREEMENT  
FOR PHYSICIAN OFFICE REMOTE ACCESS TO THE  
INFORMATION SYSTEMS**

Name \_\_\_\_\_ of \_\_\_\_\_ Physician \_\_\_\_\_ Office: \_\_\_\_\_  
(the

“Hospital”) agrees to grant me access to the Hospital’s information systems at a location remote from the Hospital, subject to the conditions set forth below. In exchange for the Hospital’s grant of remote access, I agree to the following provisions:

1. I acknowledge that through remote access I may obtain confidential patient clinical information (“Confidential Information”), and I agree to comply with all existing and future Hospital policies and procedures concerning the security and confidentiality of Confidential Information.
2. I agree not to email any Confidential Information to a non-Hospital email account. I will email Confidential Information to my Hospital email account only as allowed by Hospital policies and procedures.
3. I agree that I will not save Confidential Information to portable media devices (“Thumb Drives”, Memory Sticks, DVDs, Floppies, CDs, PDAs, and other devices).
4. I agree not to release my authentication code or device or password to any other person, including any employee or person acting on my behalf. I agree not to allow anyone else to access Hospital information systems under my authentication code or device or password. I agree not to use or release anyone else’s authentication code or device or password. I agree to notify the Hospital’s Information Technology Services (ITS) Department immediately if I become aware or suspect that another person has access to my authentication code or device or password. Furthermore, I understand that my staff or assistants will not be able to access this system without prior approval by the Information Systems Department and their own unique user ID and logon.
5. I agree not to allow any unauthorized person to use or access the Hospital’s information systems either onsite or remotely. I agree not to allow my staff, family, friends or other persons to see the Confidential Information on my computer screen while I am accessing the Hospital’s information systems. I further agree to fully log out of all networked systems before leaving my workstation.
6. I agree to follow all Hospital policies and procedures concerning access, use and disclosure of patient health information. I agree to access Confidential Information only for those individuals with whom I or the physician(s) for whom I work have a treatment relationship. I also agree to access only the amount of Confidential Information necessary to perform my job functions related to that treatment relationship. Any other access requires the express permission of the Hospital.

7. I agree that I will never access Confidential Information for “curiosity viewing.” I understand that this includes viewing Confidential Information of children, other family members, friends, or coworkers, unless access is necessary to provide services to patients with whom I or the physician(s) for whom I work have a treatment relationship.
8. I agree to maintain adequate security procedures for the computers on which I access the Hospital’s information systems, including firewalls, password management practices, and appropriate and current anti-virus software approved for use by the Hospital Information Technology Services Department. I agree that my computer will require a password for access that is a minimum of six characters long and be a combination of alpha-numeric characters.
9. I agree that at a minimum, my computer will be a computer with a 2.0 or higher GHz processor, 256MB RAM memory, video card that supports 1024x768 w/ 24 bit color, Windows XP, Internet Explorer 6.0 or higher, and a 17” (or larger) monitor. I understand that if I am a power user and review large multi frame cine clips I may be required to install at a minimum 1 GB RAM memory. I understand that while some Hospital applications may run on other brand computers (i.e., Apple MACs) and/or browsers (i.e., Opera, Firefox, Mozilla, etc.), they are not approved by the Hospital’s vendor or Information Technology Services, and I agree that these are (1) run at my own risk, and (2) may further limit the ITS Department’s ability to support the application or device.
10. I understand that the hours of support by the Hospital Information Technology Services (ITS) Department for remote access will be between the hours of 8:00 a.m. – 5:00 p.m., Monday through Friday. Remote support is limited to password resets and application support only.
11. I understand that it is not the responsibility for the Hospital ITS Department to support and/or repair my computer,ISP connection, applications or Web Browsers.
12. I agree that if I sell, transfer or donate my computer, I will contact the Hospital Information Technology Services Department, and permit them to review the hard drive for any Confidential Information.
13. I agree that the Hospital may audit my compliance with this Agreement. I agree to allow the Hospital to inspect any computer I use for remote access, including those located in my home, office or other facility.
14. I agree that my obligations under this Agreement will continue in the event my medical staff privileges with the Hospital are terminated or expire, my employment ends, or in the event the Hospital terminates my remote access under this agreement.
15. I agree that any breach of this Agreement will be considered a material breach of this Agreement, and that breaches are treated as a very serious matter. I agree that, in the event I breach any provision of this Agreement, the Hospital has the right to terminate my remote access and to refer the matter to the peer review process as a breach of

confidentiality as defined in the Bylaws of the Professional Staff, with or without notice at the Hospital's discretion. I also acknowledge that, if I am employed, my employment may be terminated and that I may be subject to penalties or liabilities under state or federal laws.

16. I agree that, in the event I breach any provision of this Agreement, I am responsible for my actions. If the Hospital is required to bring an action to enforce this Agreement, I agree to pay the Hospital its expenses, including reasonable attorneys' fees and court costs.

---

Name (Please Print)

---

Signature

---

Date

---

Phone number

**If the Confidentiality and Use Agreement is Signed by an Employee of the Physician Practice:**

I verify that I am an owner of the above-named Physician Practice. I agree that, in the event one of my employees breaches any provision of this Confidentiality and Use Agreement, I am responsible for the actions of my employees. If the Hospital is required to bring an action to enforce this Agreement, I agree to pay the Hospital its expenses, including reasonable attorneys' fees and court costs.

---

Name of Owner of Physician Practice (Please Print)

---

Signature

---

Date

---

Phone number