Access to Confluence Health EHR Confidentiality and Security Agreement

I understand that in the performance of my healthcare clinical or operational duties on behalf of

_____
(Organization)

I'm requesting access to Confluence Health (CH) Electronic Health Records (EHR) system(s) below:

☐ EPIC Hyperspace ☐ EPIC Link (Read only) ☐ Other:_____

☐ Intranet ☐ No access needed (Sponsor) ☐ Network ☐ IConnect (view diagnostic images)

As a condition of this access, I understand and agree to the following:

1. I will conform to HIPAA regulations and state law regarding Protected Health Information (PHI).
2. I will access only the information that I need to effectively perform my job on behalf of the Organization. I will not use my access for any other purpose.
3. I will not use or divulge to any other person any information obtained from CH data except as required for healthcare treatment, payment, or operations. I will not transfer or relay CH PHI or data in a place or in a manner that may compromise the confidential nature of the information provided.
4. I will not divulge or make known to any other person, my unique identifiers (i.e., username and password) that provide authentication to CH information systems. I will use only those identifiers assigned to me by CH. I will not use or attempt to use identifiers assigned to other individuals when accessing CH information systems. If I have reason to believe that my password is known by someone else, I will promptly reset my password and notify the CH Help Desk at 509 433-3500.
5. I will not leave my computer unattended while connected in a remote session to CH information systems. When finished with a remote session, I will promptly log off the system and end the connection.
6. I will immediately report any breach or possible breach of PHI to my supervisor and the CH Help Desk at 509 433-3500.
7. I agree to hold Confluence Health harmless from and against any and all claims, liabilities, costs, expenses and damages arising out of or in connection with my failure to adhere to the above requirements.

I have read the above conditions and understand that any violation may lead to appropriate disciplinary actions that may include termination of my relationship with CH and the Organization. Violation of these conditions is also subject to Washington State and Federal laws.

Requestor's **Printed Name**	Signature	Date
Position/Department	Work Email Address	Work Phone Number

Sponsor agrees to notify CH of any change in the requestor's relationship with the Organization, e.g., termination of employment, change in position, that would change the requirements for access to Confluence Health EHR. Contact Privacy Officer, at 509-436-4483 or email Privacy@confluencehealth.org

Organization Sponsor Printed Name	Signature	Date
Role of Sponsor in the Organization	Work Email Address	Work Phone Number