Data Access Acceptable Use Agreement
for Non-Providence Workforce Members (Attachment A)

Providence Health & Services ("Providence") requires that everyone granted access to our information systems will protect our patients' information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and other applicable state and federal laws.

I acknowledge that (*please initial*)**:**

_____Providence is granting me access to systems and information owned or operated by Providence or one of its subsidiaries, and I will have access to confidential information not generally available or known to the public, including protected health information (PHI).

_____Providence will issue me a unique user ID and password. I agree that I am not permitted to share this user ID or password with anyone. I will never share my password or leave it written down for others to find, nor will I utilize user ID and password auto save functionality on any computer or mobile device.

_____I agree to immediately notify Providence by calling the Breach Reporting Hotline **866-406-1290**, if I have a reason to believe that any other person may know my user ID or password.

_____I understand my computer account and password will be considered my computer signature, and I will protect it accordingly. I will keep PHI out of sight and secure it when not in use to prevent unauthorized access.

_____ Federal and state laws protect Providence information to which I will have access, and I will abide by those laws. I understand what qualifies as PHI and that I am required to comply with the HIPAA Privacy and Security Rules.

_____ I agree that I will not access Providence information for which I have no legitimate need. I will not access my own records or records of my family members. I will only access minimum necessary information for which I have a legitimate reason. I understand all activity is tracked based on my user ID.

_____ I agree that I will hold Providence information in strict confidence and will not disclose or use it except (1) as authorized by Providence; (2) as permitted under written agreement between Providence and the Organization named below or myself; (3) consistent with the reasons for my access; (4) solely for the benefit of Providence, its patients, its members, or its other customers; or (5) as required by applicable law.

_____If I am a member of a Providence medical staff, I understand I may be given access to certain tools as an important part of the delivery of medical services to Providence patients and I will use the tools to benefit Providence patients while engaged in activities that benefit Providence or its patients. I understand that the continuing medical education (CME) I may redeem from these tools is provided to me as a medical staff incidental benefit. I indemnify Providence for any liability if this benefit is not compliant with applicable law.

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_____I understand that e-mail is not a secure, confidential method of communication. I will not include confidential patient information in e-mail communications, unless using an approved secure email method.

_____I understand that should I need to use Providence network, email, or telephone, it is a privilege that may be revoked if I misuse these services. I also understand that these services may be monitored and audited by Providence.

_____I understand that should I need to work with Providence data outside of the systems to which I am granted access, I will use secure methods to dispose of files or documents containing PHI or other confidential information.

_____I understand that if I breach the terms of this agreement, applicable Providence privacy and/or security policies, or applicable law (including without limitation the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH), Providence may terminate my access, and Providence will be entitled to all remedies it may have under written agreement or under applicable laws, as well as to seek and obtain injunctive and other equitable relief, or contact law enforcement.

_____I will report all suspected privacy and security incidents immediately, but no more than 5 days from the date of discovery, to Providence's toll free **Breach Reporting Hotline number at 866-406-1290**.

I acknowledge that I have read and understand the Providence Non-Employee Acceptable Use Agreement.

Signature: _____Date: ___/___/____

Printed Name: _____Position_____

Organization's Name: _____Work Location: _____

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Each individual who will access Providence systems must completely fill in the fields before requesting access.
Please print clearly when answering the questions below.

☐ New account ☐ Change account ☐ Delete account

☐ Physician ☐ Physician staff ☐ Other

User First Name:		**MI:**	**Last Name:**		
Job Title:				**Credentials/DEA #:**	
Organization:					
Work Address:					
City:			**State:**	**Zip Code:**	
Phone Number:		**Email:**			

Select the type of account your are requesting, either Hyperspace OR EpicCare Link, and your role.

☐ **Hyperspace**	☐ **EpicCare Link**
☐ Physician/PA/ANP	☐ Physician/PA/ANP
☐ Nurse in a surgical office	☐ Site Administrator
☐ MA in surgical office	☐ Nurse/MA
☐ Biller/surgery scheduler	☐ Biller/Coder
	☐ Front Desk
	☐ Other

Account to Copy:

Name: _____

ID: _____

What do you need to view to perform your job?

_____

_____

_____

Have you had access to the Providence or Swedish network in the past? ☐ Yes, Providence ☐ No

If yes, what was your log in? _____ ☐ Yes, Swedish ☐ No

If your name has changed, what was your previous name? _____

Manager's Name:			
Manager's Phone:		**Email:**	
Manager's Signature:		**Date:**	

PLEASE FAX THIS FORM TO 907-212-5616 OR EMAIL TO: Debra.Dombovy@providence.org