

Fax back to 454-6191

**PHYSICIAN CONFIDENTIALITY AGREEMENT REGARDING ACCESS TO
ELECTRONIC MEDICAL RECORDS**

YAKIMA REGIONAL MEDICAL & CARDIAC CENTER

The Yakima Regional is committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for the hospital organization. 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 at Yakima Regional Medical and Cardiac Center to view and/or print patient information via the Internet from the HMA web site. The User ID will provide access to my patient's Electronic Medical Record, (EMR) which includes demographics, lab, medications, transcription, and radiology information and I understand that this is for my use only and will be in my possession only.

Name of Practice: _____ **Office Phone #:** _____

Physician Name: _____ (Print Full Name)

Name of Authorized Employee to Use System: _____ **(Print Full Name)**

Physician or Employee requesting access **Last 4 SSN#:** _____

If an employee is requesting access, you must provide the DOB: ___/___/___

Please provide your E-mail so we can send you information for future reference and to let you know when you've been set up in the system.

E-mail Account: _____

I further acknowledge the following:

(A) Practice shall include any physician (hereafter referred to as "physicians") practicing within the undersigned physician group, who is a member in good standing of the Hospital Medical Staff, and has privileges approved by the Hospital, and all employees (hereafter referred to as "physician authorized representative") authorized by a physician in said group to have access to the EMR under the terms and conditions of this Agreement.

(B) The Practice is allowed access to medical records of patients for whom its physician(s) is/are either the attending physician(s) of record, consulting physician(s) of record, covering physician of record or the patient's primary care physician of record. The Practice agrees not to attempt to access any medical records of patients for whom its physician(s) is/are not physician(s) of record.

(C) The only individuals who are authorized to have access to the EMR described in (B) above, are physicians and physician authorized representatives who are employed by the Practice and who have signed this Confidentiality Agreement. The physician-authorized representative must be designated by a physician member in the Practice, and shall only be entitled to access the EMR while in the employ and under the direct supervision of the physician practice member for whom the individual is the authorized representative. Access to the EMR is limited to authorized persons with a need to know, to the extent necessary, to perform their patient care related duties.

(D) The physician and physician-authorized representative can access medical records by using an individual identification number that will be assigned to him or her. The Practice understands that when an authorized individual's identification number is used to gain access to an EMR, the identification number, time of access, and the name of the patient whose medical record was accessed will be recorded. All individual authorized employees who have access to the EMR will be assigned an individual password in order to access medical records. The

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Practice will not authorize any other individuals to have access to the EMR or for individuals to use a password not specifically assigned to that individual.

(E) The computer sign-on password is the personal code of the physician or authorized employee of the physician. It is understood that this password will be changed on an every 90-day basis.

(F) The Practice understands and agrees that they must hold all medical information in confidence and not disseminate any of the accessed information for any purpose other than medical care and authorized insurance purposes. The Practice understands that any violation of the confidentiality of medical information by the Practice may result in a violation of State and Federal law and may result in a claim for damages and/or punitive action. The Practice also agrees to review this Agreement on an annual basis with all of its members. Furthermore, the Practice and its physicians and physician-authorized representatives agree that he/she has read and understands the content and information contained in this Agreement.

(G) A physician who is no longer employed by the Practice is considered to have terminated the Agreement. A physician authorized representative who is no longer employed and under the direct supervision of the physician, is considered to have terminated the Agreement. The Practice agrees to notify the Hospital immediately upon the termination by/of the physician and/or physician authorized representative.

(H) The physician must also notify the Hospital immediately upon any change in employment status and/or Hospital Medical Staff standing.

(I) Any information obtained from the EMR to which you have access is confidential and must not be disclosed to others unless the patient or his/her authorized representative explicitly consents to such disclosure.

(J) Specific state and federal requirements regarding protection of alcohol and drug abuse records, mental health records and HIV-related information prohibits you 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.

My signature below signifies I have read and understand the “*Physician Confidentiality Agreement Regarding Access to Electronic Medical Records*” in its entirety. I hereby agree to the obligations as outlined in the Agreement.

- **The form must have a supervisor/physician signature for authorizing access for office staff**

Physician/Office Manager Signature

Date

-AND-

Employee Signature

Date

To be completed by Information Systems:

Date Received Form: _____

Request Processed by: _____

USER ID: _____

Date Processed: _____