

# LifePoint IT&S Security Access Form (Havasu Regional Medical Center)

<b>Section I</b>		<b>Position:</b> NURSING STUDENT	Linda Toy – <a href="mailto:ltoy@prhc.net">ltoy@prhc.net</a> 101 Civic Center Lane, LHC , AZ 86404 Telephone 928-505-5761								
(1) Applicant Last Name		(2) Applicant First Name									
(4) Work Address <b>101 Civic Center Lane</b>		(5) City, State, Zip Code <b>Lake Havasu City, AZ 86403</b>									
(6) WORK Phone Number (Include Area Code) MCC Phone # <u>928-505-3368</u>		(7) Date of Birth	(8) SS# of Requester (REQ'D OR NO ID IS ISSUED)								
(9) User Type IF NON-LIFEPOINT EMPLOYEE BOX 10a and 10b MUST BE COMPLETED		(10a) Company Name & Phone # for Contractor/Vendor <b>MOHAVE COMMUNITY COLLEGE STUDENT</b>									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> HCA</td> <td style="width: 25%;"><input type="checkbox"/> LifePoint</td> <td style="width: 25%;"><input type="checkbox"/> Contractor</td> <td style="width: 25%;"></td> </tr> <tr> <td><input type="checkbox"/> Triad</td> <td><input type="checkbox"/> Vendor</td> <td><input type="checkbox"/> Non-Affiliate</td> <td></td> </tr> </table>		<input type="checkbox"/> HCA	<input type="checkbox"/> LifePoint	<input type="checkbox"/> Contractor		<input type="checkbox"/> Triad	<input type="checkbox"/> Vendor	<input type="checkbox"/> Non-Affiliate		(10b) Exp Date for Contractor/Vendor <b>12/11/20</b>	
<input type="checkbox"/> HCA	<input type="checkbox"/> LifePoint	<input type="checkbox"/> Contractor									
<input type="checkbox"/> Triad	<input type="checkbox"/> Vendor	<input type="checkbox"/> Non-Affiliate									
<b>Expiration and Approval Requirements</b>		Expiration date must be supplied in field 10 for "Contractors" and "Vendors". The expiration date should be the end of the contract or engagement period.									
(11) Facility ID (CO-ID) <b>02758</b>		(12) Facility / Company Name <b>Lake Havasu</b>									
(14) Department #		(15) Department Name									
(17) Universal ID		(17a) Network Login if different from UID									
(18) Applicant Signature		(19) E-Mail Address									
(13) Facility Type (Hospital, Division, etc.) <b>Hospital</b>		(16) Job Title <b>NURSING STUDENT</b>									
(17b) Domain <b>LPNT</b>		(20) Date									
<b>Authorizing Security Coordinator Statement</b> By signing this request I am stating that I have reviewed the above information for completeness and it is accurate to the best of my knowledge. Also I have reviewed the Information Security Agreement and verified that it has been completely filled out and signed. Also that I verify this request and authorize it processing. <b>2 signatures required</b>											
(21) Manager's Signature <i>Cheryl Pike</i>		(22) Security Coordinator's Signature									
(24) Manager's Printed name and date signed <b>Cheryl Pike</b>		(25) Security Coordinator's Printed Name									
		(23) Date HDIS/LSC set up account									
		(26) Phone Number of HDIS/LSC <b>928-453-0159</b>									
Applicant has Information Confidentiality & Security Agreement on File <input type="checkbox"/> Yes <input type="checkbox"/> No											
<b>Action</b>	<b>New</b>	<b>Change</b>	<b>Delete</b>								
			<b>Effective Date:</b>								

All parts of Section I MUST be completed and Applicant AND Manager signatures must be on form or ID's will not be issued.

## Section II

- NT/AD Account**
- HMS Health Management System** Check the box if AS400 is required
- Clinical View**       **Patient Care**

Security Level      SET UP AS NURSING STUDENT      **IT&S Use Only**

**DO NOT SIGN IN THIS BOX**

Application owner(print and sign name)

## Confidentiality and Security Agreement

I understand that the facility or business entity named below (the “Company”) in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the “Company”), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, “Confidential Information”).

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person’s for which I am personal representative via the company systems. The Company’s Privacy and Security Policies are available through the Company , copies of which will be provided upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient’s name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Company’s Privacy and Security Policies at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of Company employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
  - a. Use only my officially assigned User-ID and password (and/or token (*e.g.*, Multi-Factor Authentication “MFA”).
  - b. Use only approved licensed software.
  - c. Use a device with virus protection software.
15. I will never:
  - d. Share/disclose user-IDs, passwords or MFA.
  - e. Use tools or techniques to break/exploit security measures.
  - f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Facility Information Security Officer, or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient’s record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.
19. I understand that the Company may, at its sole reasonable discretion, rescind any person’s access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility’s rules and regulations, may subject me to disciplinary action pursuant to the facility’s medical staff bylaws .

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician <b>Signature</b>	Facility Name and COID HRMC	<b>Date</b>
Employee/Consultant/Vendor/Office Staff/Physician <b>Printed Name</b>	Business Entity Name Mohave Community College	