

Coffee Regional Medical Center 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 Coffee Regional Medical Center computer systems to view and/or print patient information either via the Internet from the Coffee Regional Medical Center's web-site or while performing my job inside the Coffee Regional Medical Center facility. The User ID given to me by Coffee Regional Medical Center will provide access to patient's Electronic Medical Record (EMR) and I understand that this is for my use only and will be in my possession only.

Name of Practice: _____

Physician Name: _____

Name of Authorized Employee to Use System: _____

I further acknowledge the following:

- (A) Practice shall include any physician (hereafter referred to as "physician") practicing within the undersigned physician group, who is a member in good standing of the CRMC Medical Staff, and has privileges approved by CRMC and all employees (hereafter referred to as "physician authorized representative") authorized by a physician in said group to have access the EMR under the terms and conditions of this agreement. _____(initial)
- (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) for 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. _____(initial)
- (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 be entitled to access the EMR while in the employ and under the direct supervision of the physician practice member for who 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. _____(initial)
- (D) The physician and physician authorized representative can access the electronic medical record via a User ID and password assigned to them by Coffee Regional Medical Center. The Practice understands that when an authorized individual's User ID and password are used to gain access to the EMR, the User, time of access, and the name of the patient whose medical record was accessed will be recorded. CRMC will conduct routine audits of the system. Variances will be investigated and appropriate action taken. _____(initial)

(E) 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 State and Federal law may result in claim for damages and/or punitive action. Such persons are subject to the following penalties:

* A fine of up to \$50,000 or up to 1 year in prison or both;

* If the offense is committed under false pretenses, a fine of up to \$100,000, up to 5 years in prison or both;

* If the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain or malicious harm, a fine up to \$250,000 or up to 10 years in prison, or both.

HIPPA also provides for civil fines to be imposed by the Secretary of DHHS "on any person" who violates a provision of it. The maximum is \$100 for each violation, with the total amount not to exceed \$25,000 for all violations of an identical requirement or prohibition during a calendar year. _____(initial)

(F) 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 and/or physician authorized representative. _____(initial)

(G) Specific State and Federal requirements regarding the protection of alcohol and drug abuse records, mental health records, HIV-related information prohibits you from making any further disclosures of said information without the specific written consent of the person to whom it pertains, or is otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. _____(initial)

(H) The Practice understands that failure to abide by the above Agreement may result in termination of Practice's rights to access Coffee Regional Medical Center computer systems and/or disciplinary action and/or legal action. _____(initial)

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 obligation as outlined in the Agreement.

Authorized Employee Signature (Legal Name) Date

Printed Legal Name

Last 4 digits SSN _____ Date of Birth _____

This information is needed to build your security ID in Physician Webstation.

Contact info/ Phone # _____
Where we can reach you if questions or to give your log in information.

Please fax agreement to CRMC's IT Department at 912-383-6984