INTERMOUNTAIN MEDICAL IMAGING

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FACSIMILE TRANSMITTAL SHEET

TO: Rachel Bergmann	FROM:
OFFICE:	DATE:
FAX NUMBER FOR IMI: (208) 384-9023	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	
RE: Web Ambassador login request forms	CONTACT NAME AT IMI: Rachel – (208) 384-9060 Ext. 2

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Please fill out all highlighted areas and verify that both forms are signed appropriately. We must receive both the SAR as well as the Access Agreement for each request. Once IMI/GSR receives your forms they will process them accordingly. Our goal is to get you access to web ambassador in as timely a manner as possible.

Please call with any questions. Thank you!

SAR Access Request for DR Web Ambassador

Request Information

Request Date: ____________________ Start or Effective Date: ____________________

Type of Request (Select One):

- ☐ New Access for Current User
- ☐ Terminate All User Access
- ☐ Change User Information
- ☐ New Access for New User
- ☐ Remove Access for Current User
- ☐ Change User Name (from to): ____________________
- ☐ Transfer User – Add Access
- ☐ Suspend Current User

SARMC Sponsoring Department: ____________________

Sponsor's Full Name: ____________________

Sponsor's Email Address: ____________________

Sponsor's Delegate Information (if applicable)

Sponsor's Delegate Name: ____________________

Last *First* *M.I.*

Delegate's Email Address: ____________________

Sponsor's Relationship to the User (Select One)

- ☐ MO/TH Hiring Manager
- ☐ MO/TH Manager of Volunteers
- ☐ MO/TH Manager of dept in which Volunteer works
- ☐ MO/TH Representative of Student's Education prog
- ☐ Credential Phys who contracts w/vendor that employs user
- ☐ MO/TH Business Owner of relationship w/managed facility
- ☐ MO/TH Business Owner of relationship w/vendor
- ☐ MO/TH Business Owner of relationship w/Joint Venture
- ☐ MO/TH Business Owner of relationship w/unrelated Phys or Facility

User's Information

User's Name: ____________________

Last *First* *Middle Name.*

User's Email address: ____________________

User's Last 4 Digits of SSN: ____________________ User's Title: ____________________

Name of Business or Educational Institution: ____________________

Business Contact Name: ____________________

User's Business Address: ____________________

User's Business Contact Phone Number: ____________________

User Type (Select One)

- ☐ Temporary Staff or IT Contractor
- ☐ MO Vendor's Employee
- ☐ Volunteer
- ☐ Nursing Student
- ☐ Other Student (specify):
- ☐ Cred Phys' Vendor's Emp
- ☐ External Auditor's Employee
- ☐ Payer's Employee
- ☐ Researcher
- ☐ Joint Venture's Emp (MO owns <50%)
- ☐ Joint Venture's Emp (MO owns >51%)
- ☐ Unrelated Physician (NOT MO Cred)
- ☐ Unrelated Physician's Emp or Facility's Emp
- ☐ Other Type (specify):

User's Primary Function (Select One)

- ☐ Auditing
- ☐ Billing / Collections
- ☐ Coding
- ☐ Discharge Planning
- ☐ Obtaining Test Results
- ☐ Physician Support
- ☐ Scheduling
- ☐ Treating / Caring for Patients
- ☐ Other (specify)

System / Application Access Request (Select and/or Specify)

- ☐ DR
- ☐
- ☐
- ☐
- ☐

Specify any application access needed: ____________________

Request Instructions

Complete this form and fax to Boise System Access at 208-367-3952. Scanned requests and agreements can also be e-mailed to BO-SystemAccess@sarmc.org. Notice of the user's account will be e-mailed to the Sponsor or Sponsor's Delegate when set-up is completed.

A signed Confidentiality and Network Access Agreement must accompany a new request.

SAINT ALPHONSUS HEALTH SYSTEM/TRINITY HEALTH CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT

The following rules for Confidentiality and Network Access apply to all non-public patient and business information (Confidential Information) of Saint Alphonsus Health System (SAHS), Trinity Health, and related organizations. The rules also apply to the non-public and business information of joint ventures, or of other entities and persons collaborating with Saint Alphonsus Health System and Trinity Health, to which the user has access. As a condition of being permitted to have access to Confidential Information relevant to my job function or role I agree to the following rules:

1. Permitted and required access, use and disclosure:

- I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other health care operations functions permitted by HIPAA and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.
- I will access, use or disclose Confidential Business Information only for legitimate business purposes of Saint Alphonsus Health System or Trinity Health.
- I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including:
    - making sure that paper records are not left unattended in areas where unauthorized people may view them;
    - using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential information from my workstation or other device;
    - appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded;
    - safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smartphones, PDAs, CDs, and USB thumb drives.
- I will disclose Confidential Information only to individuals, who have a need to know to fulfill their job responsibilities and business obligations.
- I will comply with Saint Alphonsus Health System/Trinity Health's access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.

2. Prohibited access, use and disclosure:

- I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by Saint Alphonsus Health System/Trinity Health policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at Saint Alphonsus Health System to gain access to my own PHI in medical and other records.
- I will not use another person's, login ID, password, other security device or other information that enables access to Saint Alphonsus Health System/Trinity Health's computer systems or applications nor will I share my own with any other person.
- If my employment or association with Saint Alphonsus Health System/Trinity Health ends, I will not subsequently access, use or disclose any Saint Alphonsus Health System/Trinity Health Confidential Information and will promptly return any security devices and other Trinity Health property.
- I will not engage in any personal use of Saint Alphonsus Health System/Trinity Health's computer systems that inhibits or interferes with the productivity of employees or others associated with Saint Alphonsus Health System/Trinity Health's operations or business, or that is intended for personal gain.
- I will not engage in the transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission, values, policies or procedures of Saint Alphonsus Health System/Trinity Health.

- I will not utilize the Saint Alphonsus Health System/Trinity Health network to access Internet sites that contain content that is inconsistent with the mission, values and policies of Saint Alphonsus Health System/Trinity Health.

3. **Accountability and sanctions:**
    - I will immediately notify the Saint Alphonsus Health System/Trinity Health Security Official or Privacy Official if I believe that there has been improper/unauthorized access to the Saint Alphonsus Health System/Trinity Health network or improper use or disclosure of confidential information in electronic, paper or oral forms.
    - I understand that Saint Alphonsus Health System/Trinity Health will monitor my access to, and my activity within, Saint Alphonsus Health System/Trinity Health's computer system, and I have no rightful expectation of privacy regarding such access or activity.
    - I understand that if I violate any of the requirements of this agreement, I may be subject to disciplinary action, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.
    - If I lose my security device I will report the loss to the Trinity Health Resolution Center immediately and I may be charged for its replacement.

4. **Software use:**
    - I understand that my use of the software on Saint Alphonsus Health System/Trinity Health's network is governed by the terms of separate license agreements between Trinity Health and the vendors of that software.
    - I agree to use such software only to provide services to benefit Trinity Health.
    - I will not attempt to download, copy or install the software on any other computer.
    - I will not make any change to any of Trinity Health's systems without Trinity Health's prior express written approval.

5. **Network:**
    - I understand that access to Saint Alphonsus Health System/Trinity Health's network is "as is", with no warranties and all warranties are disclaimed by Trinity Health.
    - Trinity Health may suspend or discontinue access to protect the network or to accommodate necessary down time. In an emergency or unplanned situation Trinity Health may suspend or terminate access with out advance warning.
    - Trinity Health may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason.

6. **Employer acceptance of responsibility for an individual with access to Confidential Information:** (<u>Applies to physicians/physician practices; other individual or facility providers; a vendor that is not a business associate; payers; any other unaffiliated organization</u>).
    - I accept responsibility for all actions and/or omissions by my employees and/or agents.
    - I agree to notify the Trinity Health Resolution Center within 5 business days if any of my employees or agents who have access to Trinity Health systems or applications no longer need or are eligible for access due to leaving my practice/company, changing their job duties or for any other reason.
    - I agree to report any actual or suspected privacy or security violations made by my employees and/or agents to the Saint Alphonsus Health System/Trinity Health Privacy Official or Security Official.
    - I understand that Saint Alphonsus Health System/Trinity Health may terminate my employee and/or agent's access.

SAINT ALPHONSUS HEALTH SYSTEM/TRINITY HEALTH
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT
SIGNATURE PAGE
RELATIONSHIP TO SAINT ALPHONSUS HEALTH SYSTEM/TRINITY HEALTH

I am a: (Please check all that apply to you)
Direct relationships with (Saint Alphonsus Health System)
___Associate (employee) at (Saint Alphonsus Health System)
___Physician Credentialed on (Saint Alphonsus Health System) Medical Staff
___Volunteer at the Saint Alphonsus Health System Facility
___Temporary/Contractor at the SAHS Facility: (name of agency) ____________________
___Student at SAHS: (name of educational organization) ____________________
Employed by or Associated with a Saint Alphonsus Health System Credentialed Medical Staff Member
___Medical Staff Member's Employee or Temp Staff (name of practice) ____________________
___Medical Staff Member's Vendor's Employee (name of vendor) ____________________
Vendor Providing Goods or Services to Saint Alphonsus Health System
___Employee/Temp Staff of SAHS clinical services vendor: (name of vendor) ____________________
___Employee/Temp Staff of SAHS business services vendor: (name of vendor) ____________________
___Employee/Temp Staff of SAHS IT services vendor: (name of vendor) ____________________
Saint Alphonsus Health System's Joint Venture or a Facility Managed by Saint Alphonsus Health System
___Employee of a SAHS Joint Venture (name of joint venture) ____________________
___Employee of a Hospital/Other Facility Managed by SAHS (name of facility) ____________________
___Credentialed Physician on Medical Staff of a Hospital/Other Facility Managed by SAHS:
(name of facility): ____________________
___Employee or Temp Staff of a Credentialed Physician on the Medical Staff of a Hospital/Other Facility Managed by SAHS (name of physicians' practice):____________________
Other
___Unaffiliated (non-credentialed) Physician/Other Provider: (name of practice) ____________________
___Employee of an Unaffiliated Physician or Facility: (name of practice or facility) ____________________
___Employee of a Payer: (name of payer) ____________________
___Researcher (Research study name): ____________________
___Other (name of employer) ____________________

USER SIGNATURE

If there are any items in this agreement that I do not understand I will ask my Saint Alphonsus Health System supervisor or other appropriate Saint Alphonsus Health System contact person for clarification. My signature below acknowledges that I have read, understand and accept this agreement and realize it is a condition of my employment or association with Trinity Health. I also acknowledge that I have received a copy of the Confidentiality and Network Access Agreement.

____
Print Name

____
Signature of individual to be given access Date

EMPLOYER SIGNATURE

Required when user is an employee or agent of: a physician/physician practice; other individual or facility provider; a vendor that is not a business associate; any other organization unaffiliated with Saint Alphonsus Health System or Trinity Health.

My signature below acknowledges that I have read, understand and accept my responsibilities as the employer or the sponsor of the user who has signed this agreement above.

____
Print Name

____
Signature of employer of the individual to be given access Date

Distribute this signed form to Human Resources if directly employed by Saint Alphonsus Health System. If associated with the Saint Alphonsus Health System Medical Staff, distribute to the Medical Affairs Office. All others should distribute to the Information Security Officer at a Saint Alphonsus Health System facility.