hoag.

Data Access & Acceptable Use Agreement *for* Non-Hoag Workforce Members
(Attachment A)

Hoag requires that everyone granted access to EpicCare Link and/or Epic TapestryLink 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*):

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

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

_____ Hoag is granting me access to systems and information licensed or owned by Hoag or one of its subsidiaries, and I will have access to confidential information not generally available or known to the public, including PHI.

_____ I agree to immediately report to the Organization's Site Administrator and call the Compliance Hotline **(800) 441-1727** or email **corporatecompliance@hoag.org**, if I have a reason to believe that security of my user ID or password has been compromised or any person may have inappropriately used or accessed EpicCare Link or Epic TapestryLink.

_____ Federal and state laws protect health 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 health information for which I have no legitimate need. I will not access records of any patient, including family members, relatives, friends, neighbors, coworkers, public figures, and even my own health records, for a purpose unrelated to treatment of the patient by me. I will only access minimum necessary information for which I have a legitimate reason. I understand all activity under my user ID is tracked and my use of EpicCare Link and Epic TapestryLink may be monitored and audited by Hoag.

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

_____ I understand that email is not a secure, confidential method of communication. I will not include confidential health information in email communications, unless using an approved secure email method.

_____ I understand that access to EpicCare Link and/or Epic TapestryLink is a privilege that may be revoked any time and for any reason.

_____ I understand that should I need to work with Hoag 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 Hoag privacy and/or security policies, or applicable law (including without limitation the HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH)), Hoag may terminate my access, and Hoag will be entitled to all remedies it may have under written agreement or under applicable laws, seek and obtain injunctive and other equitable relief, and report such breach to authorities charged with professional licensing, enforcement of privacy laws and prosecution of criminal acts.

_____ I will report all suspected privacy and security incidents immediately, but no more than 3 days from the date of discovery, to Hoag's toll-free **Compliance Hotline number at (800) 441-1727**.

I acknowledge that I have read and understand the Data Access & Acceptable Use Agreement.
Full Name (print): _____
Signature: _____ **Date:** _____

Data Access & Acceptable Use Agreement *for* Non-Hoag Workforce Members
(Attachment A)

All fields are mandatory and MUST be filled out, unless otherwise indicated.

Section I.

Office Information	**Organization/Company Name:**			
	Office Name (if different from above)**:**			
	Street Address:			
	City, State, Zip Code:			
	Phone:		**Fax:**	

Section II. *Please PRINT clearly when answering the questions below.*

User Information	**Job Title and Credentials (if appropriate):**			
	What patient information do you need for your job duties?			
	Last Name:			
	First Name:		**Middle Name:**	
	Work Email Address:			
	Request Access for:	☐ **Network ID only (no patient access; designed for Primary Contact)** ☐ **EpicCare Link (read only access to Hoag patient data)** ☐ **Epic TapestryLink**		
	Have you had previous Hoag access:	☐ **No** ☐ **Yes: What was your login user name? _____** **If you were granted access under a different name, what was it? _____**		

Section III. ***The Security Authorizer*** *is the person who is listed as the Primary Contact on the Org2Org Agreement, or the assigned designee (i.e. Site Administrator/Office Manager/Lead) who can request access or removal of access. If this request is for the Security Authorizer access, this section does not need to be completed.*

Security Authorizer	**Full Name:**			
	Signature:			
	Work Email Address:			
	Phone:		**Network ID:**	

********Please Fax or Email all pages of this form to Health Information Management Services*********
Fax: (949) 764-5934 or Email: HoagMedicalRecords@hoag.org