Connxus User Access Request Form and Confidentiality Agreement

I understand that use of Connxus information systems will allow access to confidential patient information or protected health information. I agree to access and use this information only when necessary to perform job-related duties in accordance with Connxus' established privacy and security policies.

I further understand that I must sign and comply with this agreement in order to obtain access to Connxus systems. I agree that:

1. I will keep all patient information confidential and refrain from disclosing any patient information to others, including family or friends, who do not have a need to know this information.
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. I understand that it is not acceptable to discuss confidential information even if the patient's name is not used.
4. My obligations under this agreement will continue after termination of my employment, expiration of my contract or my relationship ceases with Connxus.
5. I understand that violation of this agreement will result in revocation of all access to any and all Connxus systems.
6. I will only access or use systems that I am officially authorized to access and will not demonstrate the operation or function of systems to unauthorized individuals.
7. I will practice good workstation security measures such as logging out of any applications that contain confidential information, using passwords appropriately, and positioning screens away from public view.
8. I will practice secure electronic communications by transmitting confidential information only to authorized entities, in accordance with approved security standards.
9. I will use only my officially assigned user ID and password.
10. I will never share or disclose my user ID and password.
11. I will notify my manager, security coordinator, and/or the Connxus Security Coordinator immediately if my password has been seen, disclosed, or otherwise compromised and will report activity that violates this agreement or would adversely impact privacy or security rules.
12. I understand that Connxus will terminate my access to any or all Connxus systems if I have not logged in to the system for a period of three months or more.

Please complete and sign next page…

Please send completed form to Connxus:
info@connxus.org

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I have read the Policies and Procedures related to access and usage of Connxus systems as stated on page 1 and understand my user responsibility to maintain patient confidentiality. My signature indicates that I agree to the terms of this Connxus Confidentiality Agreement:

PLEASE CHOOSE CONNXUS SYSTEM:

☐ ICare (MPI/CDR) ☐ MedData Services (PPAP) ☐ Analytics

Specific Hospital or Clinic Location | Department

Name of User | Credentials (e.g. MD, RN, etc.)

User's Title/Position | Unique Identifier (last 4 digits of SSN)

Email Address | Business Telephone Number

Signature of User | Date

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HOSPITAL/CLINIC **AUTHORIZED REPRESENTATIVE** MUST COMPLETE THIS SECTION

I authorize the above individual to access the Connxus system(s) indicated at the top of this form. I acknowledge that as the "Authorized Representative" of a Connxus member organization, it is my responsibility to notify Connxus of any changes in this individual's job duties or employment status that would affect use of Connxus systems. I agree to cooperate with Connxus on any user administration issues, including user access, training, and security audits.

Name of Authorized Representative | Authorized Representative's Title/Position

Authorized Representative Email Address | Authorized Representative's Telephone Number

Signature of Authorized Representative | Date

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info@connxus.org