Porter - Network Usage & Sign-On Agreement

Porter is dedicated to providing Physicians with quality technological tools. It is the responsibility of all Physicians to keep the networks, servers and computers free from non-business related traffic, damaging viruses and electronic garbage. Abuse of our network systems causes expense, slowed or stopped production and destruction of hospital property

Physicians are accountable and take responsibility to guard the information resources of Porter. Accordingly, the undersigned Physician agrees:

- To take responsibility for assigned passwords to access the Porter network systems, and to never share or reveal his/her password.
- To take responsibility to secure from inappropriate uses or disclosures any patient information electronically accessed / retrieved.
- That e-mail and Internet transmissions on Porters' systems and networks are the explicit property of Porter.
- To refrain from accessing, sending or receiving material that is illegal, obscene, pornographic, hateful or defamatory in nature.
- To protect the confidential and proprietary information regarding Porter.
- To access only the data of those patient records or information for which Physician has a need to access for professional purposes, as that data is designated in Porter's HIPAA minimum necessary policies, in effect from time-to-time.
- To contact the Information Systems Department to have Physician's code changed and a new code issued, if Physician has reason to believe that the confidentiality of his or her access code has been broken.
- Physician acknowledges that the information to which he or she will be granted access involves confidential patient records and other demographic information which is governed by various privacy laws. The patient data to which Physician will have access is the same data that is available in the patient's medical record and shall be treated with the same degree of confidentiality with which the paper record is treated. In the event it is determined that Physician is accessing medical record information of which he or she has no need to know, or if it is determined that Physician is otherwise misusing access capabilities, Physician's right to access this information on

the computer system may be revoked. Physician further understands and agrees that any such violation of confidentiality provisions will be considered a violation of Porters' policies and may subject Physician to disciplinary action by the Porters' Medical Staff and/or Board of Directors.

Acknowledgement of Receipt of Policy and Request for Network Access & Password Assignment

Physician acknowledges that he or she has received and reviewed a copy of the Porter Physician Network Usage & Sign-On Authorization Policy, and understands that it is Physician's responsibility to abide by the Physician Network Usage & Sign-On Authorization Policy at all times, and to become familiar with any changes to the Policy. Physician certifies that he or she has completed the request for Network Access & Password assignment form (see reverse side).

_____

Physician's Signature

_____

Physician's Printed Signature

_____

Date

_____

Medical Staff office approval for network Access and release of password Representative Signature

_____

Medical Staff Office Representative Printed Signature

_____

Date

PLEASE FILL OUT ALL REQUESTED INFORMATION ON THE REVERSE SIDE

Network Usage & Sign-On Authorization
Request for specific application access

☐ New Account   ☐ Modify Account   ☐ Remove Account

I. PHYSICIAN INFORMATION:	**If Modify/Change**

Last Name: _____   Last Name: _____

First Name: _____   First Name: _____

Middle Init: _____   Middle Init: _____

Physician ID: _____   Physician ID #: _____

Practice/Group Name: _____

Physician Speciality: _____

Porter Physician Services Physician: **Circle - YES / NO**

Contractor: **Circle – YES / NO**

Cell Phone #: _____ *** Required for DUO remote access**

Do you currently receive patient results from Indiana Health Information Exchange (IHIE/DOCS4DOCS):
Circle – YES / NO

Preferred contact method: _____

II. Application Access includes:

Network Signon – Allows usage of the Hospitals PCs

Cerner Clinical System – Hospital Patient Care System
(CPOE, Electronic viewing of scanned documents, Electronic Signature, Patient Charting System).

PACS – Electronic Viewing of Diagnostic Images

III. For Removal of Account Only

Signature _____ Date _____

Print Name _____