Facility Application for Electronic Medical Records Access

Healogics is committed to managing the confidentiality, integrity and availability of its information technology networks, systems, and applications (“IT Systems”). This includes establishing guidelines for Remote Access to Healogics’ critical information assets maintained within the IT Systems.

It is Healogics’ policy to verify the identity and the authority of individuals requesting Protected Health Information (PHI) access in accordance with the administrative simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations at 45 C.F.R. parts 160, 162 and 164 (collectively, “HIPAA”) as well as other applicable laws. HIPAA requires Healogics to maintain PHI in systems (both electronic and paper) that have the appropriate administrative, technical and physical safeguards to ensure security and confidentiality, and to protect against reasonably-anticipated threats.

By using the IT Systems, the applicant/ user acknowledges his or her obligation to maintain the confidentiality of patient data as required by HIPAA regulations and that unauthorized users or improper use of PHI will be prosecuted. Additionally, by signing below, the applicant/user acknowledges and agrees to the following:

* I will comply with federal and state statutory and regulatory requirements (45 CFR Parts 160 and 164 (HIPAA) and the HITECH Act).
* I agree to safeguard my Healogics access account and password. I will not share my password with any other person and will not permit others to access the Healogics IT Systems through my account. I understand that I will be held accountable for all accesses made under my login and password and any activities associated with the use of my account access privileges.
* I will log out or lock computer sessions prior to leaving a computer.
* I understand that I am being given access to PHI and that my access to the IT Systems will only occur for the purpose of printing or downloading information relating to services provided by Healogics at my facility to patients of the facility so as to include that information in the patient’s paper or electronic medical record at the facility. The information disclosed under this agreement will be only used for this purpose and for such other purposes as are permitted under HIPAA and the HITECH Act, including treatment, payment, and health care operations as permitted by and in compliance with 45 CFR §164.506
* I understand that my access will be monitored to assure appropriate use
* I understand that the Secretary of the Department of Health and Human Services or the State Attorney General may investigate complaints and may seek criminal prosecution of or impose civil monetary penalties against my facility and/or me for any misuse of the access being sought.
* I will limit my access, use, and disclosure of patient information to the minimum amount necessary to perform my authorized activity or duty.
* I understand that the patient information I access is confidential and will not copy or disseminate that information except as authorized or allowed or required by law. I will discuss patient, confidential, or restricted information only with those who have a need-to-know and the authority to receive the information.
* I agree that if I terminate my position with the facility or no longer work in my current position, or otherwise am no longer functioning in the role under which access was granted, I, or my facility, will immediately notify the Healogics Help Desk at 866-412-3680, or email iheal2@healogics.com and request that my access be deactivated
* I agree to abide by this agreement and understand that these are privileges granted by Healogics to me. I further understand and acknowledge that Healogics may terminate this privilege at any time.
* I will immediately notify Healogics’ Privacy Officer by sending an email to compliance@healogics.com if I suspect any misuse regardless of whether it is intentional or not.

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| **\*Applicant name first/last**:  \* **Email address:** |

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| **\*Facility Name:**  **\*State:**  **Previous facility name:** | **\*Facility Phone:**  **Facility Fax:** |
| **Request for additional facility locations**  **Facility Names:**  **Iheal user name if account established:** | |

All areas marked with an \* must be completed. By emailing this form to postacute@healogics.com, the sender is authenticating of the account creation and that only the minimum necessary access is being sought for the Applicant.

**RETURN COMPLETED FORM TO: Email: postacute@healogics.com**