

U of L Health Care  
**Information Security Access Authorization Form**  
**Non-Hospital Employees**  
**(MD, Resident, Fellow, Student, Research, Etc.)**

*To be completed by USER*

|   |   |
|---|---|
| First Name: _____ Middle Initial: _____ Last Name: _____  |   |
| Title: _____ Degree/Credentials: _____  |   |
| Employer: _____ Dept: _____   |   |
| Do you provide service via a contract? _____ If yes, Name of Contract and expiration date: _____ Faculty: Yes ___ No ___  |   |
| <u>Authentication Information (complete all)</u>  | <u>Contact Information (at least one)</u> |
| Last 4 digits of SSN: _____   | Phone Number: _____                       |
| Mother's Maiden Name: _____   | Pager Number: _____                       |
| City you were born in: _____  | E-mail address: _____                     |
| <p>U of L Health Care Information Systems (ULH IS) is committed to protecting U of L Health Care (ULH) employees, resources, patients and partners from damaging or illegal actions by individuals, either knowingly or unknowingly. Computer resources are one of ULH's most valuable assets and shall be protected from theft, misuse, destruction or disclosure under applicable law, including Protected Health Information (PHI) covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The confidentiality, integrity, and availability of Protected Health Information must be maintained at all times.</p> <p>Therefore, I agree to the following provisions:</p> <ul style="list-style-type: none"> <li>* Not to demonstrate the operation of computer equipment, systems or resources to anyone without specific authorization.</li> <li>* To maintain assigned passwords in strict confidence and not to disclose a password for anyone, at any time, for any reason.</li> <li>* To access only computer equipment, systems and resources as required for the performance of my professional responsibilities.</li> <li>* To contact the ULH IS department immediately if any security information (including User ID and Password) is compromised.</li> <li>* Not to disclose any portion of ULH computer resources to any unauthorized individuals.</li> <li>* Not to disclose any portion of a patient's PHI except to recipients designated by HIPAA for treatment, payment or operations.</li> <li>* To report any activities that may be a breach of confidentiality to the ULH Helpdesk at <b>502-562-3637 Fax 562-4669</b>.</li> <li>* I understand that willful disclosure of my User ID and Passwords or use of another's passwords, or violation of the above terms will be considered grounds for disciplinary action up to an including denial of access to ULH systems.</li> </ul> <p style="text-align: center;">By initialing, I accept the terms of the above agreement: _____</p> <p style="text-align: center; color: red;"><b>I agree not to publish any findings, in any format, resulting from access to data provided in this request without prior IRB and Hospital approval.</b></p> <p style="text-align: center;">By initialing, I accept the terms of the above agreement: _____</p> |   |

|  |       |
|--|-------|
| User Signature:  | Date: |
| Faculty MD Signature:<br><i>(MD's require signature of Department Chair)</i> | Date: |
| Completed by (IS use only):  | Date: |

*To be completed by IS*

\* = One time Password

| Request? | Application (pls. circle if more than one selection on line) | User ID | Password |     |
|----------|--|---------|----------|-----|
| [ ]      | Novell / F5 / VPN  |         |          | [ ] |
| [ ]      | Siemens NetAccess / Soarian                                  |         | *        | [ ] |
| [ ]      | Fuji Synapse PACS  |         |          | [ ] |
| [ ]      | Other _____  |         |          | [ ] |