

Check Applicable Role

Monitor Researcher

**Research Information Security Access Authorization Form**

*To be completed by USER or Department Representative for Research Monitor*

User First Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_ User Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dept. Number: \_\_\_\_\_\_\_\_\_\_\_\_ Supervisor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

User Title/Role\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IRB#(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date:\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Authentication Information (complete all) | Contact Information (complete all) |
| Last 4 SSN : \_\_\_\_\_\_\_\_\_\_ | Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB:\_\_\_\_\_\_\_\_\_ | Pager Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender: Male / Female | E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

University Medical Center Information Systems department (UMC IS) is committed to protecting employees, resources, patients and partners from damaging or illegal actions by individuals, either knowingly or unknowingly. Computer resources are one of UMC’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.

Therefore, I agree to the following terms:

\* Not to disclose or demonstrate the operation of computer equipment, systems or resources to anyone without specific authorization.

\* To maintain assigned passwords in strict confidence and not to disclose a password for anyone, at any time, for any reason.

\* To access only computer equipment, systems and resources as required for the performance of my professional responsibilities.

\* To contact the UMC IS department immediately if any security information (including User ID and Password) is compromised.

\* Not to disclose any portion of a patient’s PHI except to recipients designated by HIPAA for treatment, payment or operations.

\* To report any activities that may be a breach of confidentiality to the UMC IS Helpdesk at **502-562-3637 Fax 502-217-8303**.

\* I understand that willful disclosure of my User ID and Passwords; use of access out of the scope of my professional role; or use of another’s passwords is grounds for termination of access.

By initialing, I accept the above terms of this agreement: \_\_\_\_\_\_\_\_\_\_

*To be completed by UMC Research Office             To be completed by IS*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Read Only Access Needed** | **Application** | ***User ID*** | ***Password*** | Complete |
| [   ] | **Cerner Medical Records** |  |  | [   ] |
| [ ] | **Aria – MedOnc & RadOnc** |  |  | [   ] |
| [ ] | **My Apps** |  |  | [   ] |

**STATEMENT OF CONFIDENTIALITY AND HEALTH INFORMATION PORTABILITY and ACCOUNTABILITY ACT (HIPAA)**

All information obtained through the hospital computer system with respect to patient’s charts, employee files, or learned through conference with physicians, employees, patients, or family members is to be handled in a highly confidential manner and is not to be discussed with anyone not directly involved.  Understand that any violation of the confidentiality of patient medical or business information penalties range from administrative action to substantial fines and imprisonment, depending on the severity of the violation.

**WHAT IS PROTECTED HEALTH INFORMATION?**

Protected Health Information is information given to a covered entity about an individual’s physical or mental condition. PHI includes the services provided by the covered entity or billing information related to the services provided. PHI also includes any information that can connect an individual to that information such as address, social security number, name, etc.

**WHEN IS PHI USED?** PHI is used when it is shared, examined, applied or analyzed.

**WHEN IS IT OK TO USE OR DISCLOSE PATIENT INFORMATION?** Covered entities can use or disclose information for the purposes of:

1. Treatment  2. Payment  3. Other healthcare operations.

**IMPLICATIONS FOR YOU:**

1. You are expected to share information only when needed and only as much as is necessary.
2. You are responsible for protecting the rights of the patients that come to University Medical Center
3. You put yourself and the hospital at risk when you share patient information inappropriately.

I have read and understand the information attached. I understand that it is my responsibility to adhere to UMC’s policies/procedures.

User:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_               \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Name                                                                              Signature                                                     Date

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Signature Date

*Submit this complete & signed form to the UMC Research Office at* [*UMCResearch@ulh.org*](mailto:UMCResearch@ulh.org) *with subject line “ISA request”*