RELIANT MEDICAL GROUP
Part of OptumCare®

Outside Entity System Access Request Form
Electronic Data Confidentiality Agreement

By signing the Outside Entity System Access Request Form, I accept responsibility to protect confidential data/information (e.g. protected health information ("PHI") and/or personal information) from inappropriate use or disclosure.

1. I acknowledge that my login information/identification is to only be used by me and that my password(s) will not be disclosed and/or shared with anyone for any reason.

2. I will contact Reliant's Help Desk at (774) 261-1357 immediately if I suspect my login information has been compromised and/or shared inappropriately.

3. I will contact Reliant's Help Desk if I terminate my employment at my company or if I no longer require access to the systems for my job responsibilities.

4. I will secure applications, safeguard systems and equipment, and lock my workstation or device to prevent damage, theft and/or unauthorized use.

5. I understand that I am not to use Reliant's electronic medical record system for any purpose outside my job responsibilities. For example, I cannot access my own medical record or the medical record of co-workers, friends, family members, or any other person for personal reasons or out of curiosity or concern.

6. I understand that I cannot discuss or disclose PHI to any person or entity outside the scope of my job responsibilities. Furthermore, I understand that I cannot copy, print, photograph or take any written notations of PHI stored in Reliant's electronic medical record system(s) for non-business use.

7. I understand that I have a legal duty and a continuing obligation to protect the privacy, confidentiality and security of PHI contained in such medical records and agree to keep such information private, confidential and secure.

8. I understand that my access will be monitored and audited by Reliant in accordance with its normal business practices.

9. I understand that in the event I inappropriately use, disclose or breach this Agreement, Reliant has the right to immediately terminate my access with or without notice and may deny future access to its systems.

10. I understand that I have a responsibility to immediately notify my supervisor and Reliant's Compliance Officer of any suspected and/or known violation of this Electronic Data Confidentiality Agreement.

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If you require secure access to a Reliant Medical Group computer system or report, in order to perform your job responsibilities, please complete the form below. Upon receipt and review by Reliant Medical Group, the request should be processed within 15 business days. Please contact Reliant's Help Desk at (774) 261-1357 for assistance or if access should be removed due to termination of employment.

If approved by Reliant IT Security, your account information will be forwarded to each authorized individual. You must log onto the system within 14 days and reset your password. Accounts will be deactivated if not used every 90 days.

Submit form to Reliant Help Desk by email helpdesk@reliantmedicalgroup.org or by fax to (774) 261-1108

Name: _____	Start Date (mm/dd/yy): Start: _____ Term: _____
Title: _____	Phone Number: _____
Department: _____	Email Address: _____
Company Name:_____ Street: _____ Town/City:_____ State: _____ Zip: _____	Verification to be used in the event you forgot your password 4-digit PIN required: _____ *Please answer two questions.* What street did you grow up on? _____ What high school did you attend? _____ What is the name of your favorite pet? _____

Information Requested: Please which application(s) you need access.

☐ eRecordLink (electronic patient record) ☐ Infinitt (x-ray images) ☐ Other _____

Access Requesting: *Please choose what functionality you need to perform.*

- ☐ View Patient demographics, appointments, medications, progress notes, lab and imaging results
- ☐ Order Patient labs and xrays **(NPI and DEA must be completed for this access)**
- ☐ Other (describe specific department usage) _____

Justification: *Please choose the business need for access to this information.*

- ☐ Physician providing direct Patient care
- ☐ Non-physician providing Patient care.
- ☐ Insurance facility providing operational needs (claims, billing, case management).
- ☐ Other (describe specific department usage) _____

Supervisor's Information:

Name Printed: _____	Title: _____
Manager's Sign off: _____	Date (mm/dd/yy): _____
Email Address: _____	Phone Number: _____

My signature below acknowledges that I have read and understand the Electronic Data Confidentiality Agreement. I accept responsibility to protect confidential data/information (e.g. protected health information ("PHI") and/or personal information) from inappropriate use or disclosure.

Print Name of Person Receiving Access:_____

Signature of Person Receiving Access:_____

Date: _____