**Information Services**
**Computerized Information Access**
Agreement for Access to the Physician Web Portal
***FOR PHYSICIAN ASSISTANT STUDENTS USE ONLY***

The declaration of this agreement extends to physician assistant students accessing the St. Luke's University Health Network Information System.

I, _____, acknowledge the receipt of my user ID and password and understand that:

- My user ID and password is equivalent to my signature.
- I will not provide my computer password to any other individual.
- I will take all reasonable steps necessary to safeguard my password from disclosure to others.
- My use of the ID and password will be strictly limited to accessing patient information at the direction of attending or resident physicians. I will not attempt to access unauthorized information.
- I understand that information contained in the database of the system is confidential in nature and cannot be disclosed or used by any individual for purposes other than that for which the information is intended.
- If I have reason to believe that the confidentiality of the password has been violated, I will contact the Information Technology department immediately for assignment of a new password.
- The use of Information Technology is a privilege extended by the hospital, which may be revised, restricted, or withdrawn at any time. These technologies are hospital property and are to be used solely for business purposes. Use of these technologies may be suspended immediately upon the discovery of a possible violation of this agreement.
- I understand that if I print any part of the patient record, such as hard or electronic copy, it will be treated with the same confidentiality as all other patient records. Destruction of copies will be in compliance with St. Luke's University Health Network policies.
- I acknowledge that as a safeguard to patient confidentiality, random audits will be conducted. I understand that I will be accountable for documented access to patient information.

I understand that I have both ethical and legal responsibilities to safeguard confidential patient information. Unauthorized use of this privilege is cause for revocation of access and other action as indicated by the St. Luke's University Health Network policies governing the confidentiality of patient information and the appropriate use of Information Technology.

I agree to amend this Agreement, as determined by the Hospital to be necessary in order to meet the requirements of the privacy regulations issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996.

I accept and agree to abide by the terms of this agreement.

_____ _____ _____
Medical student signature | Medical student name (please print) | Date

_____ _____ _____
Start date of rotation | End date of rotation (Accounts deactivated on this date) | Social Security Number