

SCHS ACCEPTABLE USE AND CONFIDENTIALITY AGREEMENT



ACCEPTABLE USE AND CONFIDENTIALITY AGREEMENT

This Acceptable Use and Confidentiality Agreement (“Acceptable Use Agreement”) is entered into on this ____ day of ____, 20____ (“AU Effective Date”), by and between **St. Charles Health System, Inc.** (“SCHS”), the authorized user _____ (“Authorized User”), and Authorized User’s employer, _____ (“Entity”). SCHS, Authorized User, and Entity may be referred to in this Agreement as the “Parties.”

PURPOSE:

The purpose of this Agreement is to set forth the terms and conditions under which Authorized User may access and/or use SCHS’s Computer Resources or SCHS Confidential Information, as defined below.

DEFINITIONS:

For the purposes of this Agreement, the following words or terms shall have the following meanings:

“**Authorized User**” means a member of the Entity’s workforce (as defined below) who has a legitimate need, and who has been authorized by Entity and by SCHS, to access a SCHS Electronic System (as defined below) for and on behalf of Entity.

“**Covered Entity**” means a health care provider, governmental or commercial health plan, or health care clearinghouse that transmits PHI electronically. Examples of covered entities include, but are not limited to, physician offices, nursing homes, pharmacies, health insurance companies, Medicare, Medicaid, and company health plans.

Hospital Electronic Health Record is patient information found in SCHS’s Epic system, a web-based service that provides health care providers and their office staff members, as well as other entities and individuals, with authorized remote access to SCHS patient information so that they can view the medical records, test results and/or other information about their patients who are receiving or have received care at St. Charles Hospitals or Clinics.

“**Minimum Necessary Standard**” means the principle or rule that the amount of PHI or other information accessed by an Authorized User shall be the least amount needed by the Authorized User to perform his or her legitimate job duties for or on behalf of Entity. As applied to this Agreement, the Minimum Necessary Standard prohibits an Authorized User from accessing the PHI or other information of an individual with whom the Authorized User or the Entity has no treatment, payment, or health care operations-related relationship.

“**PHI**” means Protected Health Information, which is information that: (1) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; (2) is oral or recorded in any form or medium; and (3) is created or received by SCHS or its workforce and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. “PHI” includes “Electronic Protected Health Information.” As used in this Agreement, “PHI” includes but is not limited to PHI obtained through the EHR System (as defined below).

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SCHS Electronic System means software, software as a service, or electronic system managed by St. Charles Health System that stores SCHS PHI or confidential information.

“Workforce” means the owners, directors, officers, employees, volunteers, professionals, agents, and persons under the direct control of Entity, where ‘direct control’ means the power and authority to contractually or through other lawful means compel compliance with the terms specified herein. For purposes of this Agreement, workforce shall include physicians and other health care providers who provide services for or through Entity. Entity is responsible for the actions and omissions of its workforce relevant to this Agreement.

TERMS AND CONDITIONS:

A. Term. This Agreement shall be effective as of the date of Authorized User’s signature below (the “Effective Date”) and shall remain in effect for a period of five (5) years, or until the earliest of:

1. The termination of Authorized User’s employment with Entity;
2. The transfer of Authorized User from a position for which access to the SCHS electronic system is needed to a position for which access to the SCHS electronic system is not needed;
3. The indictment of Authorized User for a felony, fraud, theft, or a crime involving inappropriate use of information;
4. The exclusion of Authorized User from federal or state health care programs;
5. The termination or expiration of the External User Agreement between Entity and SCHS (each, an “Event of Termination”). Entity and Authorized User each agree to notify SCHS in advance of any anticipated Event of Termination, or as soon as possible after an unanticipated Event of Termination so that Authorized User’s access can be terminated promptly.
6. Immediate termination of access by SCHS regarding Authorized User and/or Entity.

B. Rights and Responsibilities of Authorized User. By signing below, Authorized User agrees on behalf of himself or herself, and on behalf of Entity, that he or she is an employee or agent of Entity who needs to have access to patient or confidential information in a SCHS electronic system to perform his or her job duties for Entity. Authorized User also agrees:

1. To protect the privacy, confidentiality, and security of the PHI and other information accessed from the SCHS electronic system in accordance with federal and state privacy laws and regulations;
2. To comply with the Minimum Necessary Standard when accessing information and otherwise using PHI and other information obtained from the SCHS electronic system;
3. To comply with the privacy, confidentiality, and security requirements of Entity to the extent that they are more stringent than the requirements set forth in this Acceptable Use Agreement;
4. To protect from inappropriate use, and refrain from sharing his or her login username or password(s) with anyone for any reason;
5. To refrain from using any other Authorized User’s login username or password(s) for any reason;

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6. To notify SCHS's Privacy Office at (541) 706-2702, (541) 706-7760, or email at privacyofficer@stcharleshealthcare.org immediately in the event of an actual or suspected inappropriate use or disclosure of PHI or other information obtained from the SCHS electronic system or of a login username or password (each, a "Privacy or Security Breach");
7. To cooperate fully with SCHS's efforts to investigate and mitigate the harmful effects of any actual or suspected Privacy or Security Breach;
8. Except solely for internal billing purposes only, to refrain from downloading, taking screenshots of, copying, printing or pasting information from a SCHS system to any other system or device;
9. To use reasonable measures to prevent the computer screens and other devices displaying PHI and other information accessed from the SCHS electronic system from being seen by individuals who do not need to see such PHI and information;
10. To destroy copies of PHI as required by SCHS's policies as soon after the business purpose for using the information has been achieved;
11. To notify SCHS's Privacy Office immediately of any suspected and/or known violation of this Acceptable Use Agreement.

C. Auditing and Monitoring. Authorized User and Entity understand that SCHS continually audits and monitors use and accesses SCHS systems. In the event that SCHS's auditing and monitoring activities reveal evidence of a potential or actual Privacy or Security Breach, SCHS may immediately or suspend the access rights of Authorized User and/or Entity, as appropriate.

D. Consequences of Breach. In the event that Authorized User or Entity is determined to have engaged in a Privacy or Security Breach, SCHS reserves the right to pursue all remedies available under applicable laws, including seeking injunctive relief, which shall be made available without the need for the posting of a bond or other security. Authorized User understands and agrees that his or her right to (future) employment or engagement by SCHS may be adversely affected by a finding that he or she has violated the terms and conditions of this Acceptable Use Agreement.

E. Miscellaneous. This Acceptable Use Agreement shall be interpreted and enforced in accordance with the laws of the State of Oregon. All disputes arising out of this Acceptable Use Agreement that cannot be resolved through informal negotiation or mediation shall be resolved through litigation in a court of competent jurisdiction located in Deschutes County, Oregon.

F. As fair consideration for St. Charles permitting access to PHI, User agrees to fully and forever waive St. Charles from all liability. "St. Charles", includes, but is not limited to, its employees, agents, contractors, wholly owned subsidiaries and affiliates. In addition, User releases St. Charles, and its employees, agents, wholly owned subsidiaries and affiliates, fully and forever, of all liability whatsoever and will indemnify St. Charles for any damage.

G. User represent and warrant it has read, understand, and agree to comply with all requirements set forth by St. Charles. User each agree to indemnify St. Charles for damages relating to its actions and omissions.

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- H.** ST. CHARLES SHALL NOT BE LIABLE TO USER AND ENTITY FOR ANY DAMAGES, INCLUDING BUT NOT LIMITED TO; INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE OR CONSEQUENTIAL DAMAGES OF ANY KIND (INCLUDING LOST PROFITS) REGARDLESS OF THE FORM OF ACTION WHETHER IN CONTRACT, TORT (INCLUDING NEGLIGENCE AND STRICT LIABILITY), LAW, EQUITY OR OTHERWISE, EVEN IF USER OR ENTITY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. ENTITY AND USER ACCEPT ALL RISKS, KNOWN OR UNKNOWN, AND FULLY AND FOREVER WAIVE ST. CHARLES OF ALL LIABILITY.

HIPAA ACCESS GUIDELINES

You may NOT routinely access the following medical records, even though while at work you may have the ability to do so.

Please INITIAL, indicating your agreement to the following statements –

I understand that I may not access my personal lab results, physician dictated reports, x-ray reports; in short, anything in my personal medical record in any form (paper or electronic). To obtain copies of my medical records, I will sign an authorization form available from the SCHS Medical Records department.

I understand that I may not access ANY of my family members' (including children, spouses, siblings), co-workers', or acquaintances' medical records unless I am required as part of my job to obtain information for the care of that patient.

If I desire access to my medical records, I will sign an authorization form available in the Medical Record department and get such records.

I will comply with the Minimum Necessary Standard when accessing medical records.

IN WITNESS WHEREOF, the Parties enter into this Acceptable Use Agreement as of the AU Effective Date.

I UNDERSTAND THAT MY ACCESS TO ELECTRONIC PATIENT INFORMATION MAY BE REVOKED IF I AM FOUND IN VIOLATION OF THESE GUIDELINES. I UNDERSTAND THAT HIPAA LAWS AND REGULATIONS ALSO MAY APPLY.

| | |
|--|-------------|
| Print Name (First, MI, Last) – Authorized User | Date |
| Signature - Authorized User | |

[Signature page to follow]

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ACKNOWLEDGEMENT:

Authorized User

Signature: _____

Printed Name (including middle name):

Home address where you reside: (no PO Box address)

Work Email: _____

Phone Number: _____

Position Title: _____ NPI # (if applicable) _____

Date: _____

Entity's Authorized Representative

Signature: _____

Printed Name: _____

Date: _____
