



**JOHN C. LINCOLN HEALTH NETWORK
CONFIDENTIALITY AND USE AGREEMENT
FOR PHYSICIAN OFFICE REMOTE ACCESS TO THE INFORMATION
SYSTEMS**

Name of Physician Office: _____

John C. Lincoln Health Network (the "Network") agrees to grant me access to the Network's information systems at a location remote from the Network, subject to the conditions set forth below. In exchange for the Network's grant of remote access, I agree to the following provisions:

1. I acknowledge that through remote access I may obtain confidential patient clinical information ("Confidential Information"), and I agree to comply with all existing and future Network policies and procedures concerning the security and confidentiality of Confidential Information.
2. I agree not to email any Confidential Information to a non-Network email account. I will email Confidential Information to my Network email account only as allowed by Network policies and procedures.
3. I agree that I will not save Confidential Information to portable media devices (Floppies, ZIP disks, CDs, PDAs, and other devices).
4. I agree not to release my authentication code or device or password to any other person, including any employee or person acting on my behalf. I agree not to allow anyone else to access Network information systems under my authentication code or device or password. I agree not to use or release anyone else's authentication code or device or password. I agree to notify the Network Information Services Department immediately if I become aware or suspect that another person has access to my authentication code or device or password. Furthermore, I understand that my staff or assistants will not be able to access this system without prior approval by the Information Systems Department and their own unique user ID and logon.
5. I agree not to allow any unauthorized person to use or access Network information systems either onsite or remotely. I agree not to allow my family, friends or other persons to see the Confidential Information on my computer screen while I am accessing the Network information systems. I further agree to fully log out of all networked systems before leaving my workstation.

6. I agree to follow all Network policies and procedures concerning access, use and disclosure of patient health information. I agree to access Confidential Information only for those individuals with whom I or the physician(s) for whom I work have a treatment relationship. I also agree to access only the amount of Confidential Information necessary to perform my job functions related to that treatment relationship. Any other access requires the express permission of the Network.
7. I agree that I will never access Confidential Information for “curiosity viewing.” I understand that this includes viewing Confidential Information of children, other family members, friends, or coworkers, unless access is necessary to provide services to patients with whom I or the physician(s) for whom I work have a treatment relationship.
8. I agree to maintain adequate security procedures for the computers on which I access the Network information systems, including firewalls, password management practices, and appropriate and current anti-virus software approved for use by the Network Information Systems Department. I agree that my computer will require a password for access that is a minimum of eight characters long and be a combination of alpha-numeric characters.
9. I agree that at a minimum, my computer will be a computer with a 3.0 or higher GHz processor, 2gb Ram memory, video card that supports 1600x1200 w/ 24 bit color, Windows XP, Internet Explorer 6.1 or higher, and a 21” Monitor. I understand that if I am a power user and review large multi frame cine clips I may be required to install at a minimum 3gb Ram memory.
10. I understand that the hours of support by the Network Information Systems Department for remote access on the Radiology Network will be between the hours of 7:00 a.m. – 5:00 p.m., Monday through Friday. I understand that if images are needed during system or computer downtimes, I must contact John C Lincoln’s Radiology Department to make arrangements for the provision of alternate images.
11. I understand that it is not the responsibility for the Network Information Systems Department to support and/or repair my computer or ISP connection
12. I agree that if I sell, transfer or donate my computer, I will contact the Network Information Systems Department, and permit them to review the hard drive for any Confidential Information.
13. I agree that the Network may audit my compliance with this Agreement. I agree to allow the Network to inspect any computer I use for remote access, including those located in my home, office or other facility.
14. I agree that my obligations under this Agreement will continue in the event my medical staff privileges with the Network are terminated or expire, my employment ends, or in the event the Network terminates my remote access under this agreement.

15. I agree that any breach of this Agreement will be considered a material breach of this Agreement, and that breaches are treated as a very serious matter. I agree that, in the event I breach any provision of this Agreement, the Network has the right to terminate my remote access and to refer the matter to the peer review process as a breach of confidentiality as defined in the Bylaws of the Professional Staff or the Disciplinary Action Policy, with or without notice at the Network's discretion. I also acknowledge that, if I am employed, my employment may be terminated and that I may be subject to penalties or liabilities under state or federal laws.
16. I agree that, in the event I breach any provision of this Agreement, I am responsible for my actions. If the Network is required to bring an action to enforce this Agreement, I agree to pay the Network its expenses, including reasonable attorneys' fees and court costs.

Name (Please Print)

Signature

Date

If the Confidentiality and Use Agreement is Signed by an Employee of the Physician Practice:

I verify that I am an owner of the above-named Physician Practice. I agree that, in the event one of my employees breaches any provision of this Confidentiality and Use Agreement, I am responsible for the actions of my employees. If the Network is required to bring an action to enforce this Agreement, I agree to pay the Network its expenses, including reasonable attorneys' fees and court costs.

Name of Owner of Physician Practice (Please Print)

Signature

Date