

Adventist Health EpicCare Link (AH ECL) Request for Access/Site Agreement

Patient medical information is available through Adventist Health EpicCare Link (AH ECL) to qualified healthcare related individuals, facilities and their staff. This form is used to setup a new site/office on AH ECL, identify Site Administrators, and establish liability for information security.

Site Administrator: The Office is **required** to designate two Site Administrators to be the main point of contact to coordinate user access. The Site Administrator is responsible for managing requests, modification, and termination of AH ECL accounts for the designated site/office, as well as the additional duties identified below. **Note:** If two Site Administrators are not identified upon submission, the Site Agreement will be considered incomplete and may result in processing delays.

OFFICE INFORMATION

Office / Provider's Name:

Office Address:

City/Zip:

Phone Number:

FAX Number:

PRIMARY SITE ADMINISTRATOR

First Name:

MI:

Last Name:

Job Title:

E-mail Address*:

Phone Number:

FAX Number:

SECONDARY SITE ADMINISTRATOR

First Name:

MI:

Last Name:

Job Title:

E-mail Address*:

Phone Number:

FAX Number:

Site Administrator Duties

Verify Access Appropriateness

Confirm that a valid provider-patient relationship exists for records accessed via "Search All Patients"

Ensure HIPAA Training

Ensure all users accessing AH EpicCare Link (ECL) have received HIPAA privacy and security training, either through internal office procedures or by referencing federal guidelines.

Manage User Access

Remove any Authorized User's access within **2 business days** if:

- They no longer need access to PHI for treatment, payment, or operations.
- They are no longer employed by the office.

Review Site Verification Access Semiannually

Every **3 months (90 days)**, confirm that all active users associated with your facility:

- Still require access to Adventist Health EpicCare Link.
- Are current employees or agents of the office.

Report Site Admin Changes

Notify Adventist Health within **30 calendar days** of any change in Site Administrator.

Default Administrator

If no Site Administrator is designated, the individual signing this agreement will serve as the default Site Administrator.

CONFIDENTIALITY AGREEMENT FOR ONLINE SERVICES

TERMS AND CONDITIONS: As a condition of, and in consideration for, gaining access to Patient Information through the Online Services (including, but not limited to Adventist Health EpicCare Link) of Adventist Health and its affiliated institutions, I agree to this Confidentiality Agreement for Online Services.

I agree to comply with all applicable state and federal law (HIPAA) regarding access, use and disclosure of Patient Information and with all Adventist Health policies and procedures concerning the use of Patient Information and the Online Services. I agree to preserve all Patient Information, in whatever form, from loss, destruction, tampering and inappropriate access and use, including inappropriate disposal and forwarding.

I agree to access and use Patient Information (including protected health information and identity data) through the Online Services only in connection with my provision of health care-related services to individuals or to obtain payment for such services. I agree to limit my access to and use of Patient Information to what is reasonably necessary for these purposes. It is the policy and intent of Adventist Health to maintain and deliver Patient Information that is accurate, complete and timely. In some records, Adventist Health retains Patient Information created by other providers. I understand that I am solely responsible for whatever use I make of the Patient Information.

I will not share my user ID or password with others.

I agree to immediately notify Adventist Health of any security breach or threat to the confidentiality or security of Patient Information or the Online Services of which I become aware, and of the actions I have taken or intend to take to mitigate the effects of such incidents. I understand that Adventist Health may utilize security software and other measures to monitor use of Online Services and compliance with this Agreement.

I understand that inappropriate access and/or unauthorized release of confidential or protected information may result in a report to authorities charged with professional licensing, enforcement of privacy laws and prosecution of criminal acts. I further understand and agree that inappropriate access and/or unauthorized release of confidential or protected information may result in temporary and/or permanent termination of my access to Adventist Health's electronic records.

I agree to take such other actions as are necessary to carry out the purposes of this Agreement and will make my policies, procedures and other records relating to this Agreement available to Adventist Health for inspection upon request. I understand that Adventist Health may limit my access to Patient Information and the Online Services as necessary.

AUTHORIZED REPRESENTATIVE CONDITIONS:

I understand and agree that I am responsible for my workforce (my staff and others subject to my supervision) and their access to and use of Patient Information and Online Services. I agree that such use and access by my workforce shall be consistent with the terms of this Agreement.

I agree to promptly inactivate/revoke AH EpicCare Link access, within 2 business days, for any member of my workforce who has been terminated or does not need access.

I agree to adopt appropriate physical, technical and administrative safeguards to implement my obligations under this Agreement, including restricting access to and use of Patient Information and the Online Services, assuring proper password management, and implementing appropriate workforce discipline and termination procedures.

I agree to implement such security features as Adventist Health may require ensuring the security of Patient Information and the Online Services and not to attempt to alter or reconfigure access rights or methods of access. I further agree to train members of my workforce having access to Patient Information and/or the Online Services, to monitor their compliance with applicable confidentiality and security requirements, and to take appropriate disciplinary action against violations.

I agree to participate in HIPAA/confidentiality training should it be requested by Adventist Health.
By signing below, I verify that I have read, understand and agree to the conditions stated above.

Office Manager and/or Supervisor Printed Name

Title

Date

Contact Information (Phone and email) if not noted above