Central Florida Health

Central Florida Health (CFH) & Associated Affiliated Entities
Physician Office Staff/Non-Employee Confidentiality and Computer System Access Agreement

I understand and agree my System Access Credentials (login ID and password) are the equivalent of my legal signature, and I will be accountable for all computer system access made under these credentials. I understand the electronic data and information stored in the computer systems is Protected Health Information (PHI) and will treat this data with the same protections afforded PHI in the paper format.

I agree to respect and abide by all Federal, State and Local laws pertaining to the confidentiality of PHI obtained. I agree to adhere to all policies and procedures adopted to comply with the Health Insurance Portability and Accountability Act (HIPAA) governing the privacy, security and use of PHI. I will agree to amend this agreement or any separate agreement governing the exchange of PHI which includes but not limited to, demographic, insurance and billing information, as needed, to comply with such rules.

I will not access data for which I have no patient care or Peer Review responsibilities as defined in the Medical Staff Bylaws and/or rules and regulations of the CFH facilities at which I have privileges or are affiliated with.

I understand all information that may identify the patient or relates to the patient's health must be maintained in strict confidence. I will not verbally disclose or permit any person(s) to examine or make copies of patient reports or documents I come in contact with or which I create other than as permitted by CFH.

I agree to use and disclose PHI only for the purpose of treatment, payment and healthcare operations as allowed by HIPAA.

I will not use or disclose any patient information for any purpose other than the purpose stated in this agreement. I understand I am not authorized to disclose any PHI to anyone outside CFH, unless otherwise permitted by this agreement.

I will make sure all patient information in any form is returned to CFH, or destroyed in a manner that renders it unreadable or unusable as agreed upon by CFH. I agree to report immediately to CFH any non-permitted use or disclosure of Protected Health Information (PHI) made in error by myself or others I am made aware of. If I believe my System Access Credentials (login ID and password) have been compromised I will notify the CFH Information Technology Department immediately. If I no longer need computer system access or need assistance with access I will contact the CFHA Information Technology Department to assist with these requests.

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I understand the misuse of my System Access Credentials, to computer systems of CFH or Associated Affiliated Entities, misuse of confidential information, to include but not limited to Protected Health Information (PHI), may subject me to disciplinary action and immediate termination of my System Access Credentials. I understand, Federal, State and Local laws protect the confidentiality of this information and I will be personally liable for any breach of these duties and may also be held criminally liable under HIPAA privacy and security regulations for intentional or malicious use or release of Protected Health Information. I agree to report immediately to CFH any non-permitted use or disclosure of PHI made in error by me or others I am made aware of. I agree to cooperate with any investigation initiated by the Department of Health and Human Services, or healthcare related oversight agencies for the determination of CFH compliance with Federal or State privacy laws.
(Please Print Clearly)

*Signature of User: _____

*Printed Name: _____

Office Title: _____

*Name of Physician for whom you work (**Last Name, First Name**): _____

*Name of Company, Office, or Organization: _____

Address: _____

Phone: _____

*Date of Birth (mm/dd/yyyy): _____

FAX COMPLETD FORM TO 352-435-9080

(Office Manager Use)

Attention Office Manager: Please provide information listed below, so that CFH may email you in a timely manner with your office staff's username. This information is critical in getting you these credentials within a three day period after submission. If already inactivated please give CFH 72hours to reprocess and resubmit usernames. Thank you.

*Office Manger Name: _____

*Signature: _____

*Office Manger Phone: _____

*Office E-Mail Address: _____

*Date of Signing: _____