Electronic Medical Record Use Confidentiality Agreement

I hereby acknowledge that I received instruction pertaining to the proper use and consequences of any misuse of my EMR account login. I understand that all results that are finalized with my security code will be treated as a written signature with all the ethical, business and legal implications.

I understand that the computer-based patient record system will provide an audit trail of all electronic transactions that will be kept historically by UCDHS. In addition, the system will capture and retain my name, identification number, electronic signature and any other pertinent information required by UCDHS. The UCDHS Electronic Surveillance Team is charged with conducting routine reviews of all EMR system user accounts for verification of appropriate access to protected health information.

I understand and will comply with UCDHS P&P *2454 Employee Access to Protected Health Information (PHI)* and *1309, Information Security and Access*. UCDHS workforce who access or release PHI without proper authorization may be subjected to disciplinary or criminal action (if criminal intent is shown).

Depending on the severity and impact of an unauthorized use, access and disclosure of PHI, UCDHS and the employee may be subject to liability caused by anyone harmed by the inappropriate access, use and disclosure of such PHI. It is, therefore, extremely important that each UCDHS workforce, take the responsibilities for maintaining security of PHI and passwords seriously.

I agree not to share my password with any other individual or allow any other individual to use the system once I have logged into the EMR. I understand that I may have my password changed at any time by the system administrator. If I have reason to believe the confidentiality and security of my password have been compromised, I will report this information to the system administrator or my supervisor immediately.

I have read and agree with the applicable UCDHS Policy and Procedure; I assume the responsibility for keeping my password secure and confidential.

Attestation for Yearly HIPAA Privacy and Security Training (new & renewed accounts)

I hereby acknowledge that I have received my yearly HIPAA Privacy and Security training, and I understand my responsibilities related to protecting the privacy and security of the information in the EMR.
Name of Course:_____ Completion Date: _____ Instructor: _____

Workforce Signature

Workforce Signature: _____ Date: _____
Printed Name: _____ Social Security # (last 4 digits): _____
Phone: _____ Email:_____
Job Role/Title: _____ UCDHS Sponsoring Dept.: _____
Are you also a current UCDHS Employee? ☐NO ☐YES Job Title: _____

Verification of Employment and/or Verification of Student Status and Sponsor Attestation & Approval

I hereby certify that the above user is currently employed by/enrolled as a student, with _____ organization. I attest, that my department has verified the government-issued photo identification of this employee/student. Per UCDHS Policy, I will notify UCDHS immediately upon termination or disenrollment so system access may be deactivate it. I understand, this verification is in addition to the Business Associate Agreement executed between the organization and any UC Davis departments or venues.
UC Davis Sponsor/Manager or Designee Signature: _____Date: _____
Printed Name: _____
Title: _____ Department : _____