Health Connect User Confidentiality Agreement

** Incomplete forms and forms without appropriate signatures will not be processed. **

I, ____ ***(please print)***, agree to handle all information obtained through the use of Health Connect with the utmost confidentiality. I understand that Renown Health (*Hometown Health*) is granting me access to Health Connect for the use in the course and scope of my employment. I also understand that Renown Health (*Hometown Health*) has assigned to me a user ID for the sole purpose of allowing me to access Health Connect. I understand that any negligent or intentional violation of this agreement or breach of patient confidentiality using information acquired through Renown Health applications and services will be cause for immediate termination of all system privileges and appropriate discipline pursuant to Renown Health policies and procedures. Furthermore, Renown Health shall take appropriate action to comply with any and all applicable federal, state and local laws and regulations regarding such a violation including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 "(HIPAA").

Password/User ID Terms of Use:

- I agree to use only my own user ID, and will not share my user ID and password with others.
- I agree to use my unique user ID and password only in the course and scope of my employment.
- I agree to safeguard my unique user ID and password.
- I agree that I will not leave any workstation unattended for 20 minutes while being signed on to the system.

Data/Patient Information:

- I agree to comply with the applicable provisions of HIPAA and Renown Health policies and procedures related to HIPAA, patient privacy and Information Protection.
- I will not access patient or member data for any reason or purpose unrelated to my employment.
- If I believe that information security has been compromised, I will notify Renown Health Compliance immediately.
- I will not share the data obtained through Health Connect with any person, office or entity that does not contract directly with Renown Health *(Hometown Health)* for the services provided by this agreement.

User signature: ___________________________________**Title**:____

Email: ____ **Birthdate (mm/dd)** ____/____

Phone # :(_______) ____________________

Clinic/Office/Department Name AND Tax Identification Numbers:

____

***Authorized Signature:** ____ **Date:** ______/______/______

***Print Name:** ______________________________________ ***Title:** ____

Phone #: (_______) ____________________

Fax completed Form to: 775-982-8003

*For Internal Use: Date Request Received*___________________

*Account Approved*_______ *Denied*_______

*User Name*___________________________

*Password*_____________________________