Portal User Confidentiality and User Agreement

This document is confirmation to Wellmont Health System ("WHS") that I am fully aware of the implications of access to the computer systems of all WHS hospitals and affiliates and the confidentiality of the information to which I have access. I acknowledge that the data and/or information to be accessed will be patient medical record and health information that is confidential under law. I agree to maintain all such information in strict compliance with all applicable laws.

I understand that my login ID is the equivalent of my legal signature, and I will be accountable for all representations made at log in and for all work done under my login ID, including Physician Portal access by my employees, agents, or associates whether authorized by me or not. I acknowledge that nothing in this Agreement authorizes access to or disclosure of any records not otherwise permitted by law. I understand that the electronic data and information stored in the computer systems are confidential patient, financial, organizational, and practitioner data or information and must be treated with the same care as data and information in the paper records. I shall educate my employees and/or agents on their obligations to maintain confidentiality of information and to use sound information security practices when using the computer systems of WHS.

I will only access data for which I have patient care responsibilities, to perform authorized utilization review, quality assessment and improvement, payment activities or peer review participation as defined in the Medical Staff bylaws and/or policies, procedures and administrative directives of the hospital(s) at which I have privileges, and warrant that my employees, agents and associates will not access data unless directed by me for assisting me with patient care responsibilities.

I will not disclose my login ID and password to anyone including my employees, agents or associates and I will ensure that reasonable safeguards are followed to assure security over protected health information. I understand and acknowledge that unauthorized access to or disclosure of such information by me or my employees, agents or associates, may subject me to legal liability and/or cause WHS to defend a legal claim. I understand that I am responsible for any unauthorized access to, or improper disclosure of, confidential information accessed by me or my employees, agents or associates. If I believe the security of my login ID and password has been compromised or broken, I will immediately change my password and contact WHS Client Services. I understand that my use may be monitored and audits and periodic checks will be performed to confirm my involvement with patients whom I have accessed.

Should a breach in information security occur, I will notify Wellmont IS Client Services. I will exercise reasonable efforts to retrieve improperly used or disclosed Protected Health Information ("PHI"), establish, revise or adopt new practices, policies and procedures to assure that PHI is not used or disclosed in the future in violation of HIPAA Privacy Standards. I will comply with all auditing or reporting requests to demonstrate compliance with the HIPAA Privacy Standards

I understand the misuse of my permitted access to the computer systems of WHS hospitals and/or misuse of confidential information by me or my employees, agents or associates may subject me to disciplinary action, including, but not limited to, immediate termination of this agreement to access and further disciplinary action in accordance with the Medical Staff bylaws and/or rules and regulations of the hospital(s) at which I have privileges, up to and including termination of my medical staff membership and privileges as well as civil or criminal legal penalties.

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Physician's or User's Signature

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Physician's or User's Printed Name (first name, middle initial, & last name)

xxx-xx-_____ (last four digits of SSN for password verification purposes)

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Date