UF Health
UNIVERSITY OF FLORIDA HEALTH

**UF Health MyLink**
**Security and Confidentiality Agreement / Access Request Form**
**Submit to: MyLinkRequests@jax.ufl.edu**
**IT Help Desk: 904-244-7828**

## User Security and Confidentiality Agreement

I have been authorized by _____"***Name of Practice***" to access health information of current patients of the Practice, through the EpicCare Link software, a secure electronic database of protected health information (PHI) owned by **UF Health.*** Practice has entered into a separate "UF Health EpicCare Link User Agreement" with UF Health establishing the terms and conditions by which Practice and its employees and agents shall be permitted to access the aforementioned secure electronic database for the limited purpose as herein stated and Practice has authorized me, as its agent and/or employee, to receive individual access credentials to this database pursuant to the terms of that agreement. In consideration for receiving individual access credentials (User ID and password) and access to the UF Health database, I hereby agree as follows:

1. **Limited Purpose**: I will only access PHI for the sole purpose of obtaining health information about the treatment from UF Health provided to Practice's patients which is necessary for Practice's treatment of such patients and I will at all times maintain the confidentiality and security of any PHI I access or use. Any other use is prohibited and may subject the Practice and myself to civil, administrative and/or criminal liability. I further understand that UF Health may report any suspected unauthorized use under this Agreement (unauthorized access to or disclosure of PHI) to both the affected patients and to the US Department of Health and Human Services, Office for Civil Rights, and other law enforcement agencies or regulatory bodies with jurisdiction.
2. I understand that UF Health has implemented administrative, technical, and physical safeguards to protect the confidentiality and security of PHI and I agree not to bypass or disable these safeguards.
3. I agree to access PHI only on-line as "View Only." I will not print or make copies of records from the secure electronic database unless those records are necessary and essential for the Practice's diagnosis, evaluation and treatment of a current patient.
4. I have no expectation of privacy when using EpicCare Link to access PHI. UF Health shall have the right to record, audit, log, and monitor access to the PHI database attributed to my User ID or password.
5. I understand that my User ID and password are confidential and that I am responsible for safekeeping my password and that I am also responsible for any activity initiated by my User ID or password. If I suspect that my User ID or password has been compromised, I should immediately contact the UF Health IT Security Office.
6. I agree to practice good workstation security measures on any computing device I use to access the secure electronic database. Good security measures include, but are not limited to, maintaining physical security of electronic devices, never leaving a device unattended while in use, and adequately shielding the screen from unauthorized viewing by others.
7. I understand that only encrypted and password protected devices may be used to transport PHI.
8. I agree to immediately report any known or suspected violation of the confidentiality or security of PHI of patients of UF Health to the Compliance/HIPAA Privacy Office at (904)244-1979 or HIPAA@jax.ufl.edu.
9. My confidentiality obligations under this Agreement survive termination of this Agreement, the EpicCare Link Agreement or my employment by the Practice.

Violations of this Agreement may result in revocation of my user privileges, and UF Health may seek any civil or criminal recourse and/or equitable relief.

*For purposes of this form, UF Health includes the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., and Shands Teaching Hospital & Clinics, Inc.

## User Acknowledgement

By signing or by entering my name and other identifying information on this Agreement, I acknowledge that I have:

- Read this Agreement and agree to comply with all the terms and conditions stated above.
- Completed the required EpicCare Link HIPAA training module.

## User Access Request Form

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|---|---|
| First Name | Last Name |
| Job Title | Work Email Address (ex: janedoe@xyzphysicians.com or xyzphysicians@gmail.com) |
| Practice Name | Practice Address |
| NPI # (If Applicable) | License #/ME # (If Applicable) |
| Signature | Date |

## Managing Supervisor Acknowledgement and Agreement

I have informed this user of the following:

- A UF Health EpicCare Link username is considered the same as a legal signature and this user is prohibited from sharing their username and password with anyone.
- In the event that a password is compromised, the Practice shall immediately notify UF Health so actions can be taken to limit access and to issue a new password to the user.
- This user shall not use or disclose any medical records obtained from EpicCare Link for any purpose other than the diagnosis, evaluation, or treatment of a current patient.
- This user's access to EpicCare Link is subject to audit and review at any time by UF Health.

I acknowledge the following:

- As the managing supervisor, I will ensure that the Practice will immediately notify UF Health in the event this user ceases to be employed by the Practice, has a change in job function no longer requiring access to EpicCare Link, or for any other reason the Practice chooses to no longer provide this user access to EpicCare Link. Unless and until UF Health receives such notification, the Practice shall remain responsible for this user's actions in accessing EpicCare Link.
- The Practice shall provide annual training to its users on issues related to information security and patient confidentiality. The Practice shall maintain written records evidencing such annual training and provide copies upon request to UF Health.
- I agree to indemnify, defend, and hold UF Health harmless from any third party claims, including but not limited to attorney's fees and costs, arising from this user's failure to comply with the terms of the user agreement.

I have read, understand, and agree to the foregoing as a condition of this user being granted access to EpicCare Link.

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| Managing Supervisor First Name | Managing Supervisor Last Name |
| Signature | Date |