



## Non-Employee Confidentiality Agreement/EMR Access Request

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Last 4 SSN *If Physician</b>			
Brief description of your role in patient care and reason for access:		<b>Access Dates Needed</b>	<b>From</b>		<b>To</b>	

<b>EMR Access Requested</b>		
OncoEMR <input type="checkbox"/>	GE PACS <input type="checkbox"/>	Mosiaq <input type="checkbox"/>
<b>Requested For Position</b>		
Referring Physician <input type="checkbox"/>	Monitor <input type="checkbox"/>	Auditor <input type="checkbox"/>

Oklahoma Cancer Specialists and Research Institute confidentiality agreement for referring physician access to online patient information.

You may have access to medical information from Oklahoma Cancer Specialists and Research Institute (which is hereinafter referred to as OCSRI), and you will have access to what this agreement refers to as "confidential information." The purpose of this agreement is to help you understand your duty regarding the treatment of confidential information.

For purposes of this agreement, confidential information includes, but is not necessarily limited to, patient information, medical images, and reports.

Confidential information is valuable, sensitive and is protected from unauthorized disclosure both by law and by OCSRI policies. The intent of these laws and policies is to ensure that confidential information on will remain confidential - that is, this information will be used only as necessary to provide authorized patient care.

You hereby agree to conduct yourself in strict conformance to applicable laws governing confidential information. Your principal obligations in this area are explained below. You hereby agree to read and to abide by these duties. The violation of any of these duties may result in termination or limitation of your access to confidential information. In addition, should such disclosure violate State or Federal law, such disclosure may also result in civil and/or criminal liability.

OCSRI will not disclose protected health information unless it has first executed this signed confidentiality form.

If OCSRI becomes aware of a pattern of activity or practice of a referring doctor that constitutes a material breach or violation of this confidentiality agreement, OCSRI will take reasonable steps to cure the breach or end the violation.

If OCSRI is unable to correct or cure violation, it will terminate the agreement and the associated access where feasible.



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**I understand in performing my duties as medical staff member, community provider, group provider's care team member, or a community provider group affiliated with Oklahoma Cancer Specialists and Research Institute, I have/need access to viewing privileges for shared patient's health information. I further understand that:**

1. There are state and federal laws or regulations have established rights of confidentiality and security obligations regarding patient medical records and information.
2. If I am given computer access privileges which are identified and issued to me by a unique identification code and password, the identification code/password must remain secret and cannot be shared or used with anyone else but me. Any inquiries and/or modifications performed by me once computer access has been granted are referenced by my name via the unique identification code/password.
3. I am responsible for protecting the patient's rights to confidentiality and for maintaining the confidentiality of patient information at all times, both at work and when I am off duty according to this confidentiality agreement.
4. I will use confidential information only as needed to perform legitimate duties as a physician or care team member involved in the care of a shared patient and for no other purposes, including but not limited to:
  - a. Accessing confidential information to which I have a need to know.
  - b. Will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized by OCSRI.
  - c. Will not misuse confidential information or act in a careless fashion such that confidential information may be inadvertently disclosed.
5. I will report known violations of this Confidentiality Agreement to Oklahoma Cancer Specialists and Research Institute.
6. Obligations under this Agreement will continue after termination of access to OCSRI's confidential information. I further understand and agree that privileges hereunder are subject to periodic review, revision and, if appropriate, renewal.
7. I will be responsible for misuse or wrongful disclosure of confidential information and for failure to safeguard my access code or other authorization access to confidential information. I understand that your failure to comply with this Agreement may also result in other legal liability.
8. Should a medical staff member, community provider, or group provider's care team member be terminated, please email [help@ocsri.org](mailto:help@ocsri.org) to request access termination.

**I certify, by my signature below, that I have read, understand, and agree to the above statements and requirements regarding patient information.**

**Please sign, scan and email to [help@ocsri.org](mailto:help@ocsri.org).**

Signature	Date	OCSRI Sponsor
Employer/Title/Occupation	Address	
Telephone Number	Email Address	

**IT Use Only**

Access Given By: \_\_\_\_\_