UHS
Universal Health Services, Inc.

PALMDALE REGIONAL
MEDICAL CENTER

IS Authorization Agreement

Instructions:

1. Please print legibly and check spelling
2. Page 2-Must be completed for business/group
3. Page 3-Must be completed if applications will be accessed outside of LCH
4. Page 4-Must be completed by each individual user requesting an account
   (Example: physician, office manager, office staff, etc)

Universal Health Services, Inc.

LCH IS Authorization Agreement

Thank you for your interest and we look forward to offering you this service.

Facility Information

Facility: Palmdale Regional Medical Center — Facility Help Desk: ***(661) 382-5000 ext. 14357***

Fax Number: ***(661) 382-6199*** — E-Mail: ***Lancaster.TTS@uhsinc.com***

All questions on this form should be directed to the LCH I.S. Help Desk at (661) 382-5000 ext. 14357 or Lancaster.TTS@uhsinc.com

Account Information

(TO BE COMPLETED BY THE PROVIDER OFFICE REQUESTER)

Date: _____/_____/_____

Business Name: _____ Office Phone: (___) ____-_____

Office Contact 1:_____Title:_____

Office Contact 2:_____Title:_____

Group (if applicable):_____ Fax Number: (___) ____-_____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Authorized Users

List all individuals who will require access to private health information. Name, Title and Type are to be completed by the requestor. PRMC IS Department will create the User ID.

Name	Title	Type	User ID

Type: 1) Physician, 2) Office Personnel, 3) Vendor or third party processing service, 4) Consultant, 5) UHS Employee, 6) Volunteer

NOTE: UHS Confidentiality/Security Agreement (page 4) must be read and signed by any potential user prior to account creation.

FOR EXTERNAL ACCESS ONLY

TO BE COMPLETED BY THE REQUESTER

Environment Specifications

How many computers will be accessing the data: _____?

What type of devices will be accessing the data? _ Desktop PC _ Laptop PC

How is the Internet accessed? ˜ Network Connection _ T-1 line _ DSL _ Cable Modem

Other (describe):_____

Where is this PC Located? _____ *(example: office, home, both or laptop)*

Reason for Request

Reason for Remote Access: _ Patient Demographics _Patient Results _ Patient Orders

Other (describe):_____

Service Interest

On Average, during what hours will you be accessing the on-line system? From _____To_____

On which days? _ Mon _ Tue _ Wed _ Thu _ Fri _ Sat _ Sun

How many hours on average do you expect to be on-line each day? _____

Applications to be utilized:

_ Opus Clinicals _ Siemens Document Imaging

_ PACS _ LAN Access

Facility Authorization

(THIS AREA IS TO BE COMPLETED BY THE **FACILITY** ONLY)

I authorize the individual(s) above to have access to the services indicated in the Service Interest Section of this agreement.

Signed: _____ Date: _____

(CEO/Managing Director or his/her designee)

Print Name: _____

This authorization agreement must be signed by the CEO/Managing Director of the facility, or his/her designee, where access is requested. Additionally, the CEO/Managing Director should initial pages one through three to indicate acceptance of the parameters as specified therein.

MANAGEMENT OF INFORMATION: Information Security Agreement

Universal Health Services, Inc., and the healthcare facilities which it owns and operates are committed to maintaining the highest standards of confidentiality. The responsibility to preserve the confidentiality of all information (electronic, verbal, or written) rests with each employee, staff member and participant in the healthcare process. In the performance of their duties, employees, physicians, consultants and vendors may at some time be required to operate computer equipment or have access to software systems; this information is also confidential.

All persons are surrounded by confidential and sensitive information and must understand their personal responsibility to comply with the security policy.

I AGREE TO THE FOLLOWING:

- ✓ I agree that all sources of patient related information shall be held to the highest level of confidentiality. That means that I agree not to release or discuss any information except with those individuals directly responsible for the care of the patient(s) in question and as required by law.
- ✓ I agree to access information sources, specifically computer systems, only for purposes related to the performance of treatment, payment or other for patients at UHS facilities.
- ✓ I agree to maintain my assigned passwords that allows my access to computer systems and equipment in strictest confidence and not to disclose my (or anyone else's) password to anyone, at any time.
- ✓ I agree to contact the UHS IS department immediately if I have knowledge that any password is inappropriately revealed.
- ✓ I agree not to demonstrate the operation or attempt to operate computer equipment without authorization from the UHS IS department.
- ✓ Except as required by law or as authorized by the UHS IS department, I agree not to disclose any confidential information obtained during the course of my responsibilities. This includes, but is not limited to, patient, employee, financial, physician or medical information (electronic, verbal or written), as well as, the design, programming techniques, flowcharts, source code, screens and documentation created by UHS employees or outside sources.
- ✓ I agree that I will not load or use software that is not licensed by UHS (or otherwise lawful to use) on UHS facility equipment.
- ✓ I agree to report any and all activity that is contrary to the issue of this agreement to the UHS IS department.

I understand that this form will become an official part of my employee/medical staff/contractor file and that failure to comply with the above policy will result in formal disciplinary action, in accordance with medical staff bylaws and hospital policies, up to and including:

- Termination from Universal Health Services, Inc. or its subsidiaries in the case of employees or agents, or
- The termination, voiding or cancellation of agreements, contracts, etc. with physicians, consultants, or vendors, etc.

_____ _____

Responsible Party - Signature Responsible Party - Print Name

_____ _____

Business Name/Affiliation Date

Please mark account type that applies:

_ Physician _ Office Personnel _Vendor or third party processing service _ Consultant _Student _ UHS Employee _ Volunteer

NOTE: This page must be read and signed by any potential user prior to account creation.