Payer Access to Information Systems Acknowledgement

As a representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Payer”), I request access to the AdventHealth web-based platform to review health records.

I request this access on behalf of the Payer pursuant to the Payer Agreement entered into between the AdventHealth and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(“Payer”).

I understand that I will have access to protected health information (“PHI”) which may include, but is not limited to, information relating to:

* Individually identifiable health information that includes demographic information collected from an Individual and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.

PHI is protected by law, including but not limited to the Health Insurance Portability and Accountability Act of 1996, and by strict policies of AdventHealth.

As a representative of the Payer, I am required to abide by the applicable laws and the terms and conditions of the Payer Agreement between AdventHealth and Payer.

As a condition of and in consideration of my access to PHI, I promise that:

1. I will use the minimum necessary amount of PHI to perform my legitimate duties as a representative of the Payer. This means, among other things, that:
2. I will only access the PHI that is necessary to perform my duties as a representative of the Payer.
3. I will safeguard and not in any way divulge, copy, release, sell, loan, review, alter or destroy any PHI except as properly authorized within the scope of my professional activities; and
4. I will not misuse PHI or carelessly handle PHI.
5. I will safeguard and reasonably protect my access code or any other authorization I have that allows me to access PHI. I accept responsibility for all activities undertaken using my access code and other authorization.
6. I will report activities by any Individual or entity that I suspect may compromise the privacy or confidentiality of PHI to the Privacy Officer of AdventHealth.
7. I understand that my obligations under this Agreement will continue after termination of my relationship with the Company.
8. I understand that AdventHealth retains the right to review, revise and if appropriate, renew or cancel my access to the AdventHealth Information Systems.
9. I understand that I have no right or ownership interest in any PHI referred to in this Acknowledgement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Representative Title of Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Payer’s Date

Authorized Agent

**Payer Name and Address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AdventHealth Contact Information**

Department: Health Information Management Services

Contact Name: Migdalia Hernandez, Corporate HIM Director

Phone Number: 407-357-2180