AdventHealth Orlando System

ELECTRONIC STUDENT PHYSICIAN ACCESS AGREEMENT

This Electronic Student Physician Access Agreement, dated and effective _____is entered into by and between ADVENTIST HEALTH SYSTEM/SUNBELT, INC. d/b/a AdventHealth Orlando (hereinafter referred to as "Company"), and, ("Student Physician" which also applies to "Allied Health Student AHSTD" or "Visiting Resident or Fellow" rotating through the AdventHealth Orlando System) _____.

WITNESSETH

Whereas, the Company maintains a system of Protected Health Information ("PHI"), such as clinical and personal demographic information, which is stored and retrieved electronically;

WHEREAS, the Company's relationship with the Student Physician results from either the Student Physician's enrollment in a recognized program with an institution that has a contract with the Company for the provision of clinical training or the Student Physician's participation/enrollment in the Company's sponsored residency program ("Relationship");

Whereas, the Student Physician desires to obtain access to electronic PHI that pertains to patients primarily treated by/or in consultation attended to by Student Physician, in order to facilitate the management of the patient's medical care while on rotation;

Whereas, the Student Physician is not presently able to access Company's electronic PHI from any site.

Now, Therefore, in consideration of the foregoing mutual promises and covenants set forth below, and according to policies of the Company's Confidentiality of Information and MIS Data Security, the Company and the Student Physician agree as follows:

1. I understand that I will have access to electronic PHI which may include, but is not limited to, information relating to: Individually identifiable health information of patients 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.

2. I understand that PHI is protected by law, including but not limited to the Health Insurance Portability and Accountability Act of 1996, and by strict policies of the Company.

3. I represent and warrant that all electronic devices I will use to access Company's electronic PHI have been secured in accordance with Workstation Safeguard policy.

4. I will use the minimum necessary amount of electronic PHI to perform my legitimate duties. This means, among other things, that:
   - I will only access the electronic PHI that is necessary to perform my duties as a Student Physician;
   - I will safeguard and not in any way divulge, copy, release, sell, loan, review, alter or destroy any electronic PHI except as properly authorized within the scope of my professional activities; and ▪ I will not misuse electronic PHI or carelessly handle electronic PHI.

5. I understand that I will receive one (1) access code for my access to electronic PHI.

6. I understand that I may not release, loan, or divulge my access code to any individual nor may I use, borrow, or share the access code of any other individual.

7. I will safeguard and reasonably protect my access code or any other authorization I have that allows me to access electronic PHI. I accept responsibility for all activities undertaken using my access code and other authorization. I agree to hold Company harmless from any consequences flowing from such breach, including but not limited to, paying reasonable attorneys fees, costs and expenses incurred by Company in connection with such breach, whether or not court action is initiated.

8. I will report activities by any individual or entity that I suspect may compromise the privacy or confidentiality of electronic PHI to the Data Security Officer by **notifying the AdventHealth – AIT Support Desk at (407) 303-5580 immediately when such an incident has occurred.**

9. I understand that my obligations under this Agreement will continue after termination of my relationship with the Company.

10. I understand that the Company retains the right to review, revise and if appropriate, renew or cancel my access to the Company's information systems.

11. I understand that I have no right or ownership interest in any electronic PHI referred to in this Agreement.

12. I understand that I must attend training sponsored by Company concerning the operation and access of electronic PHI before access to clinical applications and electronic PHI will be granted to me. The date and time of said instruction will be scheduled at a mutually beneficial time.

13. I understand that all amendments to the Agreement shall be in writing and signed by duly authorized representatives of both parties; the Agreement is governed by the laws of the State of Florida; the term of the Agreement is contingent upon my continued Relationship with the Company.

14. I understand that the Company shall not be responsible for delays in retrieving electronic PHI from the system due to computer or operational failure.

15. I understand that should I breach any of the foregoing covenants, I may be subject to consequences including, but not limited to, access forfeiture, notification to my sponsoring institution, and/or expulsion from all AdventHealth Orlando System facilities.

IN WITNESS WHEREOF, the parties have executed this Agreement dated as above.

STUDENT PHYSICIAN MSTD/AHSTD or Visiting Resident/Fellow **COMPANY**

Print Name: _____ Print Name: AdventHealth Orlando

Signature: _____ Signature: PRESIDENT

School/Program: _____ Date/OPID: _____

Submit to: AdventHealth Orlando Graduate Medical Education Administration with other required clerkship documents