Third-Party/External Provider SHIMER Acceptable Use Agreement

SHIAWASSEE Health & Wellness

This "Third-Party SHIMER Acceptable Use Agreement" form must be completed, signed, and submitted for each person within your organization who requires access to the Shiawassee Health and Wellness (SHW) Electronic Health Record (EHR). Each person will be given a unique user ID with a system access level based on job responsibilities and their "need to know".

WRITTEN AGREEMENT: I, , will:

- Use SHW's Electronic Health Record (EHR) system or other assigned computer system on a "need-to-know" basis only;
- Retrieve or enter information about consumers as required for clinical care or business functions related to that clinical care only as it relates to my job duties and licensing;
- Remember that it is my legal obligation to protect the privacy and security of all Protected Health Information (PHI) and will take all reasonable precautions to protect the privacy and security of consumer information. This includes protecting my password and not leaving display screens or printed materials containing Protected Health Information (PHI) where it can be viewed inappropriately;
- Change my password so that it is known only to me and will keep it secure;
- NOT disclose my password or allow another person to log in using my User ID and password
- NOT log on using someone else's User ID and password, I understand doing so is fraud and not allowed in any circumstance

All users of SHW computer systems are bound by this agreement.

Staff Name:		Job Title:	
Staff e-mail address:		Phone #:	
Staff NPI Number:		Job Duties:	
Provider/Organization Name and Address:			
Additional Locations/Addresses Staff Needs Access To:			
Credentials after signature of billable documents:			

I will notify Shiawassee Health and Wellness of any changes in my professional licensure. I am aware that I need to sign a new Acceptable Use Agreement which is required for any change in name, licensure & changes in job duties.

Staff Signature:	Date:

As Supervisor of the above-listed employee, my signature below indicates that :

- I have read and understand this document and I assure that all stated requirements will be met.
- I agree to contact Shiawassee Health and Wellness immediately, once it has been determined that the above-listed employee no longer needs access rights to SHW's EHR, or any other assigned system, so that the appropriate security measures can be taken to discontinue access rights.

Supervisor Name:		Supervisor Credentials:	
Supervisor Signature:		Date:	
Supervisor e-mail address:			

NOTE: SHW IT department to retain agreement forms for a minimum of seven (7) years in accordance with GS20 Retention Requirements.