PHYSICIAN PRACTICE AUTHORIZATION AND ACKNOWLEDGMENT
EMPLOYEE ACCESS TO HEALTHPOINT AND PCCN VISION

I verify that I am an authorized principal/owner/officer of_____.
(Name of Physician Practice)

I authorize, on behalf of the Physician Practice, the employees listed in the "Remote Users Information" attachment to be granted access to the HealthPoint and/or Phoenix Children's Care Network's (PCCN) Vision portals ("Systems") on behalf of the Physician Practice.

I acknowledge that, by authorizing the following employees, Physician Practice is responsible for each employee's use of the Systems and their compliance with the Confidentiality and Use Agreement for Access to HealthPoint ("Agreement") including privacy and security regulations and policies as applicable. A copy of the Agreement is attached to this document.

I agree to notify PCH's Information Technology Services Department ("PCH ITS") at (602) 933-HELP within 24 hours of any employee's termination. I acknowledge that access to the Systems does not carry over from one employee/employer to another upon termination, nor are employees permitted to share identification codes and passwords with or assign access to coworkers or any other party.

I agree that, in the event any employee breaches any provision of the Agreement, Physician Practice remains responsible for any such action and must notify PCH ITS as soon as practicable, but within 24 hours, of any suspected or actual breach of security, confidentiality, or the Agreement . If PCH or PCCN is required to bring an action to enforce this Agreement, Physician Practice agrees to pay PCH or PCCN its expenses, including reasonable attorney's fees and court costs.

I understand that non-provider level users granted access to PCCN's vision will have the ability to view provider performance against PCCN's defined quality metrics for all providers in my practice.

_____
Name of Owner/Officer of Physician Practice (Please Print)

_____
Signature

_____
Date

_____
Phone Number

CONFIDENTIALITY AND USE AGREEMENT FOR ACCESS TO HEALTHPOINT

Phoenix Children's Hospital (PCH) agrees to grant me access to the HealthPoint System, subject to the conditions set forth below. In exchange for PCH's grant of access, I agree to the following provisions:

1. I acknowledge that through HealthPoint access I may obtain confidential patient demographic, financial, clinical and business proprietary information ("Confidential Information"), and I agree to comply with all existing and future PCH policies and procedures concerning the security, confidentiality and privacy of Confidential Information.

2. I agree not to, in any way, divulge, copy, release, sell, or loan any Confidential Information.

3. I agree that I will not save Confidential Information to portable media devices ("thumb drives", memory sticks, DVDs, floppies, CDs, PDAs, and other devices) or hard copies.

4. I agree not to release my identification code (ID) and password to any other person, including any employee or person acting on my behalf. I agree not to allow anyone else to access the HealthPoint System under my ID and password. Furthermore, I agree not to use or release anyone else's identification code and password.

5. I agree to notify PCH's Information Technology Services (ITS) Department at (602) 933-HELP immediately if I become aware or suspect that another person has access to my identification code and/or password. Furthermore, I understand that my staff or assistants will not be able to access this system without submitting a Confidentiality and Use Agreement with approval by the ITS Department and their own unique user identification and logon has been assigned.

6. I agree not to allow any unauthorized person to use or access the HealthPoint System either onsite or remotely. I agree not to allow my staff, family, friends or other persons to see the Confidential Information on my computer screen while I am accessing the HealthPoint System. I further agree to fully log out of all PCH networked systems before leaving my workstation.

7. I agree to follow all PCH policies and procedures concerning access, use and disclosure of patient health information (available upon request). I agree to access Confidential Information only for those individuals with whom I or the physician(s) for whom I work have a treatment relationship. I also agree to access only the amount of Confidential Information necessary to perform my job functions related to that treatment relationship. Any other access requires the express permission of PCH.

8. I agree that I will never access Confidential Information for "curiosity viewing". I understand that this includes viewing Confidential Information of children, other family members, friends, or co-workers, unless access is necessary to provide services to patients with whom I or the physician(s) for whom I work have a treatment 'relationship.

9. I agree to maintain adequate security procedures for the computers on which I access PCH information systems, including firewalls, password management practices, and appropriate and current anti-virus software approved for use by PCH's ITS Department. I agree that my computer will require a password for access that is a minimum of eight characters long and be a combination of alpha-numeric characters under the guidelines of generally accepted security practices.

10. I agree to immediately report to the PCH Office of Business Integrity any use or disclosure of protected health information (PHI) received from PCH for purposes other than those permitted by this Agreement and any security incident that I become aware of that affects PHI created on behalf of or received from PCH by calling the PCH Information Technology Services (ITS) Department at (602) 933-HELP.

11. I understand that the hours of support by PCH's ITS Department for remote access will be between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Remote support is limited to password resets and application support only.

12. I understand that it is not the responsibility of the PCH ITS Department to support and/or repair my computer, ISP connection, applications or web browsers.

13. I agree to wipe clean the hard drive prior to sale, transfer, or donation of my computer according to Department of Defense 5220.22-M wipe pass standards. I will contact the PCH ITS Department at (602) 933-1964 and permit them to review the hard drive for any Confidential Information.

14. I agree that my compliance with this Agreement may be subject to review and/or audit by PCH.

15. I agree to allow PCH to inspect any computer I use for remote access, including those located in my home, office or other facility. Further it is understood that this device will be blocked from accessing the PCH network and other systems except those permitted by HealthPoint.

16. I agree that my obligations under this Agreement will continue in the event my status with PCH is terminated or expires, my employment ends, or in the event PCH terminates my remote access under this Agreement.

17. I agree that any breach of this Agreement will be considered a material breach of this Agreement, and that breaches are treated as a very serious matter. I agree that, in the event I breach any provision of this Agreement, PCH has the right to terminate my remote access, with or without notice at PCH's discretion.

18. I agree that, in the event I breach any provision of this Agreement, I am responsible for my actions. If PCH is required to bring an action to enforce this Agreement, I agree to pay PCH its expenses, including reasonable attorneys' fees and court costs.

PCCN Vision: Administrative User Request

If you plan to request access to the PCCN Vision tool for any of your administrative staff please consider the three options below. The definitions below will provide you with a brief overview of the type of access that each user role will have within the Vision tool.

Clinical Support Staff: A user who has the Clinical Support Staff user role will have the ability to log in as any provider at your practice. With this login, the user will be able to submit supplemental patient information (known as supplemental data within the tool) into the system on behalf of the providers at your practice. All supplemental data entered by these users are tracked via internal audit trail for full transparency on data entered into the system. The main function of this user role is to submit supplemental patient data, develop outreach notifications, and ensure provider activities are tracked within the tool.

Practice Manager: The users with the Practice Manager role should be limited only to the staff at your practice who your practice feels comfortable having access to view each of your provider's performance against the PCCN Quality Metrics. The Practice Manager role will allow the user the ability to compare and contrast provider scores against the quality metrics, build custom reports, log in as a provider, enter supplemental data on behalf of a provider, and view overall practice performance.

Practice Manager w/ no ALAP: A user who has the "Practice Manager w/ no ALAP" user role will have the ability to log into the system and see things the way a user with the Practice Manager User role would minus the ability to log in as a provider. This user will have the ability to see the high level report on performance of the practice against the PCCN Quality Measures, your practice providers' performance against the PCCN Quality Measures, and the ability to access the patient outreach features within the tool.

Should you have any questions or concerns while filling out this form please do not hesitate to contact PCCN at 602-933-7226.

Remote Users Information (Please Print)

[Must be completed by the Physician Practice Owner/Officer or their designee ("Representative")].

Name/Title of individual completing form_____.

NOTE: All remote users must complete the Confidentiality and Use Agreement for Access to HealthPoint or PCCN Vision.

Requesting Access to: ☐ **HealthPoint** ☐ **PCCN Vision**

If PCCN Vision is selected, please denote Vision account type:

☐ **Clinical Support Staff** ☐ **Practice Manager** ☐ **Practice Manager w/ No ALAP**

First Name: _____ **Last Name:** _____

Business Email Address: _____ **Phone Number:** _____

Title: _____ **Department:** _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ **HealthPoint** ☐ **PCCN Vision**

If PCCN Vision is selected, please denote Vision account type:

☐ **Clinical Support Staff** ☐ **Practice Manager** ☐ **Practice Manager w/ No ALAP**

First Name: _____ **Last Name:** _____

Business Email Address: _____ **Phone Number:** _____

Title: _____ **Department:** _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: _____ Last Name: _____

Business Email Address: _____ Phone Number: _____

Title: _____ Department: _____

Name of Physician Practice Representative Authorizing Remote Access: _____

Signature of Representative Authorizing HealthPoint/Vision Access: _____

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: Last Name:

Business Email Address: Phone Number:

Title: Department:

Name of Physician Practice Representative Authorizing Remote Access:

Signature of Representative Authorizing HealthPoint/Vision Access:

Requesting Access to: ☐ HealthPoint ☐ PCCN Vision

If PCCN Vision is selected, please denote Vision account type:

☐ Clinical Support Staff ☐ Practice Manager ☐ Practice Manager w/ No ALAP

First Name: Last Name:

Business Email Address: Phone Number:

Title: Department:

Name of Physician Practice Representative Authorizing Remote Access:

Signature of Representative Authorizing HealthPoint/Vision Access:

Add additional sheets for additional names to cover all authorized users.