



DOCUMENT IMAGING AND ON-LINE CHARTCOMPLETION  
SYSTEM ACCESS AND CONFIDENTIALITY AGREEMENT

I understand that my user ID and password are unique identifiers for the document imaging system, and I am accountable for all access and entry made to the system in which my user ID and password is used. I accept responsibility for all activities undertaken using my password. I agree to safeguard passwords assigned to me and will not disclose them to anyone for any reason. I will not allow others to use my password and I will change my password every 90 days as required by the system. I understand I must terminate any active computer sessions before leaving a computer terminal unattended in order to prevent others from gaining access under my password or viewing confidential patient information. I acknowledge I am not to use anyone else's user ID and password to obtain access to the document imaging system.

I understand an electronic signature is a security tool that may be used within the document imaging system as an additional identification check and qualifies as my official signature. I am aware that electronic signature codes require the same level of protection as any other computer system password. I will not allow others to use my electronic signature code to authenticate documents for me.

If I have reason to believe the confidentiality of my password or electronic signature code has been compromised, I will contact the system administrator to have my password or electronic signature code changed. I will immediately report any known or suspected breach of the confidentiality of the system, or data obtained from it, to my department chair or immediate supervisor.

I am aware that patient information, whether it is accessed through the document imaging system, another electronic system, or on paper, is confidential and protected by law from unauthorized disclosure. I understand that improper access to, or unauthorized modification or disclosure of data may subject me to the imposition of criminal penalties and/or disciplinary or adverse action, as appropriate. Similarly, if I exceed my computer system access authority or use that authority to engage in conduct outside the scope of my official duties, I may also be subject to disciplinary or adverse action and criminal prosecution.

I will use confidential information only as needed by me to perform my legitimate duties as a MUSC/UMA employee. This means I will not access confidential information which I have no legitimate need to know and I will not in any way divulge, copy, release, sell, loan, revise, alter, or destroy any confidential information except as properly authorized within the scope of my employment. Further, I will not misuse, carelessly treat, or fail to safeguard confidential information. I understand the person who prints the document is responsible for the appropriate destruction of that document. Audits may be conducted to ensure compliance with this policy. I understand my obligation to protect sensitive information does not end with the termination of my access to MUSC computer systems or with termination of my MUSC/UMA employment. I understand that under conditions where security violations are suspected, an audit trail may be used to reveal and/or track my computer activities on the document imaging system.

I affirm that I have read and understand the provisions and intent of this agreement and the importance of preserving confidential information and maintaining computer access security. I understand that all conditions and obligations imposed upon me by this agreement apply during the time I am granted access to the MUSC document imaging system and at all times thereafter. I will abide with the document imaging system access and confidentiality policies and procedures.

Applicant's Full Name (Please Print Clearly): \_\_\_\_\_

Job Title: \_\_\_\_\_ Department/Unit: \_\_\_\_\_

Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Employee Number: \_\_\_\_\_ Net Id: \_\_\_\_\_

Reason for Access: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Departmental Chair or Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Please complete the above and return to Health Information Services, room 269 Main Hospital, or fax to (843) 792-5460. **Your user ID and password will then be generated and emailed to your MUSC account.**)