UCLA HEALTH Information Serices & Solutions (ISS) / 176746 10880 Wilshire Blvd., Suite 500 Los Angeles, CA 90024 Phone: (310) 267-4560 / Fax: (310) 794-7895	**VENDOR ACCESS REQUEST FORM**	ISS USE ONLY USER ID:

PLEASE TYPE (or print legibly) REQUIRED INFORMATION BELOW.

(1) **LEGAL NAME** (Last/First/Initial) **[**REQUIRED**]**	(2) TITLE	(3) TELEPHONE (Work) **[**REQUIRED**]** ( )

PLEASE CHECK THE APPROPRIATE BOX:
☐ NEW APPLICATION ☐ ACCESS CHANGE ☐ INFORMATION CHANGE

(4) ORGANIZATION AND MAILING ADDRESS **[**REQUIRED**]** (Department/Room no./Building or Street Address/City, State & Zip)	(5) SECRET WORD for identity verification [REQUIRED]

(10) ACCOUNT/ACCESS REQUESTED:

NETWORK	**EMAIL**	**SERVER**	**CARECONNECT**	**OTHER**
☐ AD Domain	☐ Exchange	Please specify:	Please specify	Please specify

NOTES, COMMENTS, REQUESTS:

UNAUTHORIZED COMPUTER USE:

Unauthorized use of UCLA Health Sciences computer equipment and/or data could result in the termination of my access. In addition, should I so misuse UCLA Health Sciences computer equipment and/or data, I further acknowledge and agree that the University has the right to, under its agreement with Epic Systems, remove me from work on all UCLA contracts. Such unauthorized use may also constitute grounds for either civil action (for restitution) or criminal prosecution by a third party other than University.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT:

_____ _____
Applicant Signature [REQUIRED] Date[REQUIRED]

(12) AUTHORIZER **[**REQUIRED**]**	
_____ / _____ _____ Signature / Print Name Date	

ISS USE ONLY (RITM)

Completed By:	Date:

UCLA Health

CONFIDENTIALITY STATEMENT
For Non-Workforce Members

The federal Health Insurance Portability and Accountability Act ("HIPAA") and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient. In certain circumstances, HIPAA allows the disclosure of limited patient information in order to carry out treatment, education, research, public health, or health care operations activities without obtaining the patient or subject's authorization.

Confidential Patient Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note this information is defined in the Privacy Rule as "protected health information.") Examples include but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computerized patient data;
- Visual observation of patients receive medical care or accessing services; and
- Verbal information provided by or about a patient.

I understand and agree that this document establishes a Confidentiality Agreement between me _____ [insert name of Individual] a representative of _____[insert name of employer] and UCLA and sets forth the understanding regarding the protection of any confidential information that Individual may have access to while performing services at UCLA with the following purpose:

_____

1. I understand that I will be granted access to, or otherwise become acquainted with, the following information ("Information") relating to UCLA patients:

   ☐ Clinical/medical information
   ☐ Insurance and Billing information
   ☐ Scheduling information
   ☐ Visual observation of patients receiving medical care or accessing services
   ☐ Other (describe)_____

It is understood and agreed that except as required by law, I will use and hold all Information in strict trust and confidence, and will use such information only for the purposes contemplated herein, and not for any other purpose.

UCLA Health

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2. I acknowledge that it my responsibility to respect the privacy and confidentiality of Information received from UCLA. I will not access, use or disclose patient or other confidential information unless I am authorized or permitted to do so by law or as authorized by the patient I further understand that I am required to immediately report any information about unauthorized access, use or disclosure of confidential patient information to UCLA.

3. I agree to not disclose the Information to any other individuals.

4. Neither the release of any Information hereunder or the act of disclosure shall constitute a grant of any license under a trademark, patent, or copyright or application of the same.

5. I understand and acknowledge that, should I breach any provision of this Confidentiality Statement, I may be subject to civil or criminal liability.

_____ _____

(Signature) (Date)

_____

(Print Name)