CHILDLINK™
ACCESS REQUEST FORM

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

Office/Hospital Name: _____

Title: _____

Address: _____ **Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

E-Mail Address: _____

If Physician, NPI #: _____

Confidentiality Agreement:

1. I understand it is my responsibility to ensure that patient data/information is kept strictly confidential, and therefore must not be displayed or visible in the presence of any person not entrusted with the care of the patient. Any violation of this rule can result in termination of the ChildLink agreement, loss of privileges at Nationwide Children's Hospital, or civil and/or criminal action against me.
2. I understand that I may be aware of and have access to Nationwide Children's Hospital Laboratory Services confidential information. Confidential information includes, but is not limited to, patient information or medical records in any form (verbal, paper, or electronic). Confidential information may **only** be used or discussed when required to perform patient care.
3. I agree to use caution to avoid being overheard when discussing any confidential information, especially in public areas. I understand that any violation of confidentiality may result in disciplinary action.
4. I will access confidential patient information only if needed to support patient care. I understand that retrieving/viewing/printing information (computerized or paper) on friends, relatives, neighbors, celebrities, or co-workers is a breach of confidentiality and U.S. Federal Law, and can result in termination of privileges and legal sanctions or termination of access. I will refer all requests for disclosure to the Nationwide Children's Health Information Management Department (614-722-3662).
5. I understand that access to a computer system(s) is a privilege, and at no time am I authorized to use any system for other than its intended use or for personal gains, or the gains of another.
6. I will make sure the patient record is not left open and unattended in areas where unauthorized people may view it.
7. I understand that I shall notify Nationwide Children's Hospital at least five (5) business days in advance of any planned change my employment status, such as termination, medical or parental leave, resignation, or other extended leave of absence longer than two (2) weeks.

Continued on back

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

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Information Security Agreement:

1. I will only use my own password. I understand that my password is an electronic signature which will be attached to each transaction I enter into the ChildLink system. I am legally responsible for the accuracy of the information I enter into the ChildLink system. All inquiries, data entries, reporting, and orders performed using my password is permanently recorded and subject to auditing.
2. I will not allow anyone to access the ChildLink system using my password. In addition, I will not use passwords other than my own, nor will I access any part of the ChildLink system for which I am not authorized.
3. If I must leave a workstation unattended for any reason, I will exit the ChildLink system so no unauthorized person may access or enter information under my identity.
4. I understand my access to ChildLink will be terminated as soon as I terminate association with Nationwide Children's Laboratory Services.

ChildLink™ Access Agreement:

1. As a ChildLink user, I understand that Nationwide Children's Outreach Services will only provide support for ChildLink during normal business hours, Monday through Friday.
2. I understand that if an unauthorized person learns my password, this person can assume my identity. Any action taken by this intruder will be attributed to me in the ChildLink system's security log, and may result in legal action against me.
3. This Agreement shall be construed as broadly as necessary to implement and comply with all Federal and State Regulations. Nationwide Children's Outreach Services reserves the right to further revise this Agreement as may be required for Federal and State regulatory compliance.

My signature below indicates I have read, understand, and agree to the above Confidentiality and Security standards. I understand that a violation of any part of Confidentiality and Security standards could result in disciplinary action, termination of Nationwide Children's Hospital privileges, or civil and/or criminal action.

I agree to defend, indemnify and hold harmless Nationwide Children's Hospital, including its officers, directors, and employees, from any damages, losses, claims, demands and costs (including attorney's fees) caused by, resulting from or arising out of my breach of this Agreement, including, but not limited to, my unauthorized access of patient data/information and my delegation of my password.

Signature: _____ Date:_____

Please fax completed form to (614) 355-4459. Attention: Bong Ng / Erin Antonopoulos / or James Ranjitsingh at Nationwide Children's Outreach Services.

FOR OUTREACH SERVICES USE ONLY

Date:_____ **Approved:**_____ **Denied:**_____ **Reason:**_____

User ID Assigned_____ **Security Level Assigned:**_____

By: _____