CC ms Care Connection - MEDICAL/PA Student CC ms

*(Please print and write legibly. The **Bold** and * items are required. If you omit any of the required fields or the form is illegible the request may not be processed or may be delayed)*

***Hospital, Choose one only:**

☐ **Christ** ☐ **Good Sam** ☐ **Shepherd** ☐ **Condell** ☐ **Masonic** ☐ **Trinity** ☐ **South Sub** ☐ **Lutheran**

***Name:** _____ _____ _____
(Last) (Middle) (First)

***Last 5 Social Security #:** _____ School: _____

Start Date: ____/____/____ ***End Date:** ____/____/____
(Assumed ASAP if no date) *(Assumed one month from the time received if no date)*

Confidentiality Agreement:

As a non-employee of Advocate Health Care, you or your representatives may have access to patient, medical record, employee or other confidential information. As a condition to being granted such access, you are required to agree to the following:

I understand that in the course of my working relationship with Advocate Health Care, I share the responsibility of maintaining the confidentiality of any patient, medical record or employee information that I may have available to me. I understand that it is my responsibility to follow Advocate Health Care policies and procedures as they relate to the assurance of patient rights and the confidentiality of information both written and verbal.

Computer Systems: I understand that I may receive a unique User-Id and a personal password necessary for me to gain access to an Advocate Health Care computerized system. I understand and agree that both the User-id and my Password are for my own personal use and are not to be disclosed to or used by third parties. If at any time I feel that the confidentiality of my User-id or password has been compromised, I will contact appropriate management (Advocate employee that approved your access) for direction within 24 hours.

Conduct and Confidentiality: I understand that I must maintain the confidentiality of any written or oral patient, medical record or employee information that I have access to or view as a result of my working relationship with Advocate Health Care. I understand that the release of patient, medical record or employee information of any kind is only allowed by Advocate Health Care policy guidelines. If I am uncertain or do not understand the Advocate Health Care policy guidelines, I will contact the appropriate Advocate manager (Advocate employee that approved your access) for assistance and direction within 24 hours. I agree to only release patient, medical record or employee information under the Advocate Health Care policy guidelines or as required by law.

Patient, Medical Records and Employee Information: I acknowledge that all information involving patients, medical records and employee information is private and confidential. I agree that I shall access only that data necessary for the proper performance of my job responsibilities under my business relationship with Advocate Health Care. I further agree to keep confidential any and all information that I access, receive or transcribe, and not to disclose any such information to third parties. I am aware, that, unless specifically identified as part of my job by "Advocate Health Care", I am not authorized to discuss any information concerning a patient's or employee's personal data or medical condition. I am responsible for ensuring that discussions regarding patient, medical record and employee information are held in appropriate locations with only authorized individuals.

Any unauthorized disclosure on my part or my representatives will be a very serious offense to Advocate Health Care. Such unauthorized disclosure may result in Advocate's repossession of all of my or my representative's access to patient, medical record and employee information, Advocate may also act up to and including termination of my business relationship with Advocate and asserting its full rights under the law.

***Student Signature** _____ Date _____

Access Required: ☐ MEDICAL Student ☐ With Order Entry

☐ PHYSICIAN ASSIST. Student ☐ Without Order Entry

***Does this student require access to psychiatric** *(confidential)* **units?** ☐ **YES** ☐ **NO**

If yes, please explain: _____

Authorized by: *(Please make sure all of the above are correct)* *(Upon receipt please allow 3 to 4 business days to complete this request)*

Print Name: _____

Title/Dept: _____ **Phone #:** _____

_____ **Date:** _____
(Authorizing Signature**)**

Forward this request to:
IS Security Administration, AHC Support Center, 1400 Kensington Rd., Oak Brook IL 60523
***or** Fax to **630-575-5395** c/o IS Security*

(↓ For Information Systems Security Administration Use Only ↓)

Completed by: _____ Date: _____

CC ms