DATE:___/___/___

YALE NEW HAVEN HOSPITAL

NO.

REMOTE ACCESS FOR BUSINESS SERVICES EMPLOYEE REQUEST FORM

This request is for: ☐ a Portal Account ☐ VPN Account

A. APPLICANT IDENTIFICATION: ***[Fill in all of Section A completely, noting affiliation, department location, & duration].***

Name:_____
(Last) *(first)* *(MI)*

Department: _____ EMP#: _____
(Medical Staff Office ID, if assigned to you)

Affiliation: ☐ YNHH ☐ HSC ☐ BH ☐ GH ☐ TEMPLE ☐ OTHER_____

Office Location:_____Phone:_____

E-mail address:_____Beeper:_____

DURATION OF USE ☐Permanent ☐Temporary from: _____ to _____

B. HARDWARE INFORMATION: (Please provide required information which best describes the computer that will be used for remote access).

Check One ☐ **I use personal PC**. Is your personal PC wireless? ☐ Yes ☐ No
Name of your Internet Service Provider (ISP)_____

☐ **I use a Hospital PC** (i.e. portable/laptop)

Check One	**I log on to**	☐ YNHH Network	☐ Med school Network	☐ Other or N/A
	I need access	☐ from home	☐ from my office	☐ on the road

C. REASON FOR ACCESS: ☐ Email Only ☐ Email & Desktop ☐Other_____
(Indicate Applications to access on 2nd page.).
Critical Business Function_____

_____

_____

D. CURRENT NETWORK ID, if applicable_____

E. AUTHORIZING SIGNATURES – REQUIRED (V.P. or Administrative Director only)

_____ Date _____
[signature]

_____
[print name and title]

F. OTHER FORMS:
This form must be accompanied by YNHH's Confidentiality Agreement and Addendum for Remote Access

SECADM:_____ DATE:_____/_____/_____

For assistance in completing this form, call the MIS HELP DESK, 688-4357

YALE NEW HAVEN HOSPITAL

REMOTE ACCESS TO BUSINESS SERVICES REQUEST FORM

APPLICATIONS TO BE ACCESSED:

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

11

12)

E. AUTHORIZING SIGNATURES – REQUIRED (V.P. or Administrative Director only)

_____ Date

[signature]

_____

[print name and title]

SECADM:_____ DATE:_____/_____/_____

INSTRUCTIONS FOR REQUESTING REMOTE ACCESS TO YNHHS NETWORKS

THIS FORM IS FOR EMPLOYEE REQUESTS ONLY.

(For vendors select 'Non-Employee Access Forms')

Users' Requirements: NO MACS OR WINDOWS *ME, No Vista at this time*

GENERAL INFORMATION:

Please note the requirements. You must be using approved software and hardware or the access may not be achieved. Standard Access is for a period of one year. Renewals are automatic provided you continue to work in the same department and ***none of the original information changes***. .

Changes in employment or department will result in your access being shut off.

Inactivity (no access in 180 days) may result in your account being shut off. Your account may be reactivated by a request from your manager if inactivity is less than 360 days. Inactive accounts over 360 days may be deleted and reinstatement will require a new request.

Note all of the required information***. Requests omitting required information will be rejected***.

The request must be accompanied by a signed YNHHS Confidentiality Agreement and the Addendum for Remote Access**.**

Forward the completed and signed form along with the Confidentiality Agreement & Addendum

Carol Zaffino/Christine Hauser
IS&T Security Administration, Suite 111E
300 George St.
New Haven, Ct, 06511

Do not send faxes or copies. Originals are required.

All requests must be authorized by the VP or Administrative Director responsible for the employee or vendor/consultant.

You will be notified by email when your account has been generated and ready for use. The VPN client CD can be mailed to you interoffice or you may pick it up here at George Street. Bring Identification (your badge is OK).

*** * * * * * * * * * * * * * * ***

INSTRUCTIONS FOR REQUESTING REMOTE ACCESS TO HOSPITAL NETWORK

FILLING OUT THE FORM:

Check which form of Remote Access you are applying for, Portal or VPN.

Section A: <u>Required Information</u>:

Full Name and Middle Initial (no nicknames please)
Department or Service
Employee Number
Affiliation -- Your employer, who gives you your paycheck
Office location / business address
Phone Number
E-mail address
Duration

Section B: <u>All information is required</u>.

Section C: <u>All information is required</u>. Check which functions you wish to access.

Applications desired are to be listed on page two. ***A second signature*** authorizing the applications off site is required. You may use the applications page to describe other functions required ***. Requests will not be processed without Critical Business Function description.*** . Use back side if more room is needed

Section D: <u>Required</u>.. Specify your current network ID if you have one.

Section E: <u>Required</u>: This request must be ***authorized/signed by your Department's Administrative Director or Vice President.*** If other signatures are required, you will be notified. This should not be necessary for standard requests.

Request No.

SECURITY AND CONFIDENTIALITY AGREEMENT
ADDENDUM FOR REMOTE ACCESS

It is recognized that supplying access to sensitive YNHH patient and administrative data to perform job-related activities from locations outside of the Medical Center may increase the opportunity for violation of YNHH data security and confidentiality policies. Therefore, the remote access user's cooperation is critically important and expected in maintaining the integrity of YNHH data security and confidentiality. As such, the remote access user agrees to adhere to the following guidelines:

1. The computer used for remote access must be within complete control of the user during the remote access session.

2. Remote access passwords, user ID's and other codes will NEVER be shared with any other individuals. Each user must have his/her own remote access account and codes.

3. All data accessed via remote access will be treated confidentially, just as though it were accessed from within the Medical Center. Additionally, all paper copies of data will be shredded or destroyed in accordance with YNHHS policy.

Signature
Name
Date

YALE NEW HAVEN HEALTH SYSTEM

CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

I understand that as an employee, member of the medical staff, physician office employee, or non-YNHHS patient care provider or support personnel (volunteer, intern, student, contractor, vendor, etc.) of Yale-New Haven Health Services Corporation ("YNHHS"), the performance of my job may require me to access or become aware of the following confidential information:

- Patient health care and financial information (otherwise known under HIPAA as Protected Health Information)
- Employee personnel, compensation and health care information
- Physician performance and personnel information
- Business information relating to YNHHS (including financial, administrative, resource management, and other information)

By signing below, I agree to the following:

a. I understand that approval to access and use this information in verbal, written, or electronic (stored in computer) form is a privilege. I also understand that access to YNHHS information is granted to me based on business or clinical "need to know" standards and the responsibilities of my job as an employee, member of the medical staff, or non-YNHHS patient care provider or support personnel. I agree that I will not use or disclose any confidential information accessed by or provided to me, except in connection with my responsibilities on behalf of YNHHS. I agree to access information only on patients for whom I, my office, area, or department has responsibility. Patient information may be used for research or teaching purposes only when authorized by the appropriate institutional review board and in compliance with YNHHS Policies and Procedures.

b. I understand that the methods I use to get information may only be used in the performance of my job. I understand that if granted a sign-on code, password, and/or "physical token device" that I accept full responsibility for any use or actions taken with my sign-on code(s), password(s) (codes), physical token device Personal Identification Numbers (PIN), and recognize that, in some cases, these codes are the EQUIVALENT OF MY SIGNATURE. The codes will be used only by me and I will not use another person's codes at any time. I will notify the YNHHS IS "Help Desk" immediately should my code(s) be compromised in any way, or if my token is lost or stolen. I will reimburse YNHHS for the cost of the token, if not recovered. **Violation of this rule** will result in **For Physicians:** disciplinary action up to and including dismissal from the Medical Staff and/or House Staff of a member Hospital; **For Employees:** disciplinary actions under the guidelines of the entity Human Resources Policies and Procedures; **For Non-Employees:** disciplinary actions up to and including immediate termination of your relationship with YNHHS, and possible legal action against you and the organization you represent.

c. I understand that I may not seek information that is not required to do my job. I understand that an audit trail, noting my code(s) or PINs, the patient, or system accessed and the date may be reviewed by YNHHS. I understand patient information accessed through the computer is considered the same as the patient's medical record and may not under no circumstances be re-disclosed except in compliance with applicable federal and state laws, including without limitation the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the terms of that certain HIPAA Required Business Associate Agreement executed between the parties (the "BA Agreement"). I agree to store and dispose of information which I use in a way that ensures continued security and confidentiality.

d. I understand that computer hardware, software, and information are considered YNHHS property and are subject to and protected by appropriate YNHHS Policies and Procedures.

e. I understand that YNHHS reserves the right to make modifications to its access program including revoking codes and requesting the return of any token access devices.

f. I understand my access privileges will be revoked if any of the above understandings are violated.

Signature:			**Date:**
Print Name:		**EMP#:**	
Affiliation: (YNHHS Facility, Yale University, Community, Company, Other)	**Dept:** (Dept, Service)	**MSO#:** (Med Staff Ofc ID)	
Security Representative:			**Date:**