PRIVACY AND SECURITY COMMITMENT

FOR ACCESS TO BILLINGS CLINIC ELECTRONIC MEDICAL RECORD SYSTEMS

By signing this document, I acknowledge that I have been granted access to Billing Clinic's electronic medical record system. I understand that I am being given access because Billings Clinic believes that enhanced use of computerized clinical information systems by physicians, other health care providers, and their workforce (collectively, "Providers") will improve the quality of patient care by increasing coordination among treating providers and providing better and more efficient access to relevant clinical information.

I understand I will be issued a user ID and password. I will not share my User ID and password and will secure it so that it cannot be found or used by anyone else. I take responsibility for all actions taken using my user ID and password.

I understand that the information in the System is highly confidential and is protected by federal and state law and Billings Clinic policies. I agree to comply with all laws and policies regarding the information in the System.

I will only use my user ID and password to access information that I need to know in order to provide treatment or related services to the patient. I will only access the minimum amount of information necessary to perform my assigned job or function. I acknowledge that Billings Clinic maintains audit trails that track all activity for all users and that Billings Clinic conducts audits to ensure only appropriate uses of information in the System.

I agree that I will not disclose information from the System to any third parties except as necessary for treatment of the patient or as otherwise permitted by Billings Clinic. In all disclosures, I will disclose only the minimum amount of information necessary to accomplish the permitted purpose for the disclosure.

I will not store any information from the System on any device, including mobile devices. I will not print, capture screen shots, or otherwise make any copy or record of the information in the System unless specifically authorized by Billings Clinic. I will forward all requests for copies of medical records, or other patient requests to Billings Clinic for review and action. I will not use email or text messages to communicate confidential information from the System.

I agree to immediately report any misuse of user IDs, passwords, or actual or suspected breaches of information in the System, including privacy issues or security issues, to Billings Clinic's Privacy Officer at 406-657-4226.

I acknowledge that I have received and completed training on confidentiality, privacy, and security requirements, including the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") and Billings Clinic policies and procedures, on the security of my password logon, on appropriate workstation use, and on appropriate access to certain computer applications that contain protected health information. I agree to complete any additional training, including refresher courses, required by Billings Clinic. I agree to read, understand, and comply with the Billings Clinic Terms and Conditions of Use, and Billings Clinic policies and procedures, as well as Medical Staff policies and procedures, on the confidentiality, use and disclosure of protected health information. In particular, I have been given Billings Clinic's Terms and Conditions of Use, which I have reviewed and agree to abide by. I understand that current Terms and Conditions of Use and policies may be amended and new policies may be issued regarding the confidentiality, use and disclosure of protected health information, and I agree to follow any new or amended policies.

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Signature Date

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Printed Name