



# HENRY FORD LEARNING CENTER (HLC) ACCESS REQUEST FORM

ALL USERS MUST *READ AND SIGN THE USER ACCESS AGREEMENT* FOUND ON PAGE 2

## IDENTIFICATION

All portions of this section must be filled out completely and legibly

Last Name (print): \_\_\_\_\_

First Name (print): \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Employee ID#: \_\_\_\_\_

Job Title: \_\_\_\_\_ Cost Center: \_\_\_\_\_

Location (building): \_\_\_\_\_ Floor/Room Number: \_\_\_\_\_

Dept.: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employee  New Hire  Consultant  Recent Transfer (date) \_\_/\_\_/\_\_

Temporary →(deactivate date) \_\_/\_\_/\_\_

\_\_\_\_\_  
University Steering Committee  
Business Unit Representative (Print)

\_\_\_\_\_  
University Steering Committee  
Business Unit Representative (Signature)

## ACCESS

- Level 0 - Department Administrator
- Level 0 - Product-Line Administrator (please list below all cost centers)
- Level 0 - Department Administrator (view only)
- Level 1 - Business Unit Learning Administrator
- Level 2 - System Administrator

\_\_\_\_\_  
List of all cost centers user will be administering

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Fax completed forms to:*  
Organizational & Human Resource Development  
Fax: (313) 874-9547 or 74-9547

# USER ACCESS AGREEMENT

I request access to the Henry Ford Health System information systems as indicated in the Information Technology Access Request Form. In exchange for access, I agree and acknowledge that:

**1. NEED-TO-KNOW ACCESS.** HFHS patient and business information is confidential. This information is only available to me on a need-to-know basis in order for me to perform my assigned duties for HFHS (or if I am a private practice physician, to obtain information regarding my patients). This means that I cannot use my access to HFHS information systems to look up information about my family, friends, neighbors or co-workers, unless it is my job to take care of them as patients or as otherwise permitted by HFHS policy. I will not share any information obtained from the HFHS information systems with anyone who is not authorized by HFHS policy to receive it.

**2. PRIVACY AND SECURITY POLICIES.** I have read and understand the HFHS Privacy of Patient Information Policy H-001 and the security policy and agree to follow these policies. I understand that patient information can only be used and disclosed to others for the purposes specifically stated in, and using the security measures provided by, these policies.

**3. USER ID AND PASSWORD.** I understand that HFHS will issue a user ID and password to me to access HFHS information systems. I will not share my user ID and password with others. I am responsible for all access to HFHS information systems using my user ID and password, which is considered my "electronic signature" for this

purpose. HFHS may terminate my access to HFHS information systems at any time for any reason and without stating a reason.

**4. ACCURACY AND UPDATING INFORMATION.** All information provided by me in the Information Technology Access Request Form is accurate, true and complete. I will update this information if it changes or if my job or job duties change (such as following a transfer or promotion) or if my job status changes (for example, if I am an employee and become a contractor).

**5. VIOLATIONS.** If I violate this agreement or the privacy and security policies, I may be subject to disciplinary action up to and including termination of employment or contract termination, with the possibility for civil or criminal prosecution. I agree that violations will result in irreparable damages for which there is no adequate remedy at law. Therefore, in addition to monetary relief, HFHS is entitled to injunctive relief without the necessity of a bond.

**6. CONTINUED CONFIDENTIALITY.** When my association with HFHS ends, I am still obligated to keep HFHS patient and business information confidential. I must return all HFHS patient and business information to HFHS, unless HFHS has agreed in writing to allow me to keep it.

Signature: \_\_\_\_\_

Job Title: \_\_\_\_\_

Department: \_\_\_\_\_

Print Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date: \_\_\_\_\_

## IF YOU ARE AN HFHS EMPLOYEE—STOP—YOU DO NOT NEED TO FILL OUT THE REST OF THIS FORM

Additional obligations and authorizations for private practice physicians and contractors who predominately work offsite:

I am an authorized representative of:

- A private practice physician credentialed at an HFHS hospital, private practice staff members, OR
- A non-employed workforce member/association, OR
- Others identified by HFHS Information Technology as requiring these additional obligations and authorizations.

I request access to the Henry Ford Health System information systems as indicated in the Information Technology Access Request Form for the user indicated above. In exchange for access, I agree and acknowledge on behalf of my company that:

**1. PRIVACY AND SECURITY OBLIGATIONS.** My company and its employees, contractors and agents will honor the promises made by the user in this Agreement. We will not share user IDs and passwords and will sign a separate User Access Agreement and obtain a separate user ID and password for each user. We will comply with all applicable laws governing the privacy and security of patient information.

**2. COMPUTER ACCESS.** If HFHS information systems are accessed from non-HFHS locations, my company is responsible to ensure that its computer systems are properly secured and configured for access to and use of these systems. HFHS does not pay for or provide support for the configuration of non-HFHS computer systems. HFHS

does not guarantee the availability or accuracy of any data contained in HFHS information systems.

**3. TERMINATION.** All obligations which by their terms may be performed after termination of this Agreement, shall survive termination.

**4. VIOLATIONS.** My company is responsible for the actions or inactions of its employees, contractors and agents for violations of HFHS privacy and security policies, this Agreement, or privacy and security law. My company will hold HFHS harmless for any losses and damages, including reasonable attorney fees and costs, incurred by HFHS resulting from any such violations.

Company Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Work Phone No: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date: \_\_\_\_\_

**HFHS Management Approval (required)**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Work Phone No: \_\_\_\_\_

Email Address: \_\_\_\_\_