Community Physician Portal Application
Instructions

***Please note - to use the portal you must have Google Chrome or Firefox***

1. Complete the following documents with all the information that is required on the form.

2. Sign both documents and fax the completed and signed documents to 631-638-4077 or e-mail them to PhysicianOutreach@stonybrookmedicine.edu. Include a copy of your driver’s license (Please note copies do not always fax clearly, a hard copy may be required to be sent in the mail).

3. Within 14 business days you will receive an e-mail confirming the completion of your account.

4. Click on the link in the e-mail and follow the steps to obtain your user name and password.

For any questions please call 631-638-INFO (4636)
SECTION 1: MUST BE COMPLETED BY ALL - PLEASE PRINT

Phone number 638-4636
Fax completed form to 638-4077 or e-mail PhysicianOutreach@stonybrookmedicine.edu

<table>
<thead>
<tr>
<th>Name</th>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stony Brook ID Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver Lic. Number</td>
<td>Not needed if you already have a Stony Brook ID Number</td>
<td></td>
</tr>
</tbody>
</table>

*Your Driver License number will be secured by Hospital IT

| Practice Name: | |
| Title: | |

DOB

Month/Day/Year

☐ Medical Staff at SBM
☐ Non-Medical Staff at SBM

OFFICE ADDRESS: __________________________________________________________
_______________________________________________________
_______________________________________________________

OFFICE TELEPHONE: ________________________________

EMAIL ADDRESS (Mandatory): ________________________________________________

Stony Brook ID Regulations

- The Stony Brook ID number is the property of the issuer
- The Stony Brook ID shall not be transferred, altered or tampered with in any way
- Your Stony Brook ID number will be used to grant access to computer systems. You must keep your ID number secured.
- Your ID number will be used when calling the IT Help Desk (444-HELP) for any password problems.
- Photo Id required

I have read and agree to the terms and conditions listed above ______________________________

Signature (Required)

I attest that the individual named above is an employee under my supervision in my private practice. I will ensure that the confidentiality of the patient health information that the employee has access to on the SBUH information systems will be maintained.”

Physician Signature: ________________________________ Date: ______________________________
Workforce & Electronic Information Access Confidentiality Acknowledgement Statement

Important: Please read all sections. If you have any questions; have them answered before signing.

1. Confidentiality of Patient Information:

   a) Services provided to patients are private and confidential;
   b) Patients provide personal information with the expectation that it will be kept confidential and only be used
      by authorized persons as necessary;
   c) All personally identifiable information provided by patients or regarding medical services provided to
      patients, including oral, written, printed, photographic and electronic (collectively the “Confidential
      Information”) is strictly confidential and is protected by federal and state laws and regulations that prohibit
      its unauthorized use or disclosure;
   d) In my course of employment/affiliation with Stony Brook University Hospital (SBUH), I may be given
      access to certain Confidential Information;
   e) In accordance with New York State Public Health Law Article 27-F and Part 63 of 10 NYCRR AIDS
      Testing and Confidentiality of HIV-Related Information; no person who obtains confidential HIV-related
      information in the course of providing any health or social service or pursuant to a release of confidential
      HIV-related information (any information that indicates that a person has had an HIV-related test, such as
      an HIV antibody test; has HIV-infection, HIV-related illness, or AIDS; or has been exposed to HIV) may
      disclose or be compelled to disclose such information. Illegal disclosure of confidential HIV-related
      information may be punishable by a fine of up to $5,000 and a jail term of up to one year; and
   f) New York State Mental Health Law § 33.13 governs the protection, confidentiality and disclosure of
      behavioral health services/psychiatric care/substance abuse. The law strictly limits disclosure of mental
      health related information. All disclosures of mental health related information in oral, written, and
      electronic form require an authorization signed by the patient/individual or their personal representative.

2. Disclosure, Use and Access of Electronic or Hard Copy Confidential Information:

   Any information acquired or accessed during the performance of work at SBUH in the course of assigned duties or
   in contact with any of SBUH affiliates must be kept confidential. This applies to all HIPAA Protected Health
   Information (HIPAA-e-PHI) and includes employee information, financial information, research information
   and SBUH business affairs.

   Each individual working in the SBUH computer systems environment is responsible for protecting the privacy
   of the SBUH patients’ information (HIPAA-e-PHI), employee information, financial information, research
   information and SBUH business information. They must also take care to preserve confidentiality of such
   information in conversations, and in handling, copying, storage of, and disposal of documents and any and all
   electronic media that contains such information.

   Access to SBUH networking systems and HIPAA-e-PHI systems, employee information systems, financial
   information systems, research information systems and SBUH business affair systems is permitted on an as
   needed basis only for the required performance of assigned responsibilities and does not allow access to any
   information that is not part of one’s duties and responsibilities on a need to know basis, including one’s own
   personal electronic information. The HIPAA privacy regulation allows for copies of personal information
   when requested through proper channels. Any violation of this acknowledgement or SBUH and SBU
   policies and procedures is strictly prohibited.

   SBUH networking and computer systems require access approval to obtain user passwords for accessing
   systems. Each person is responsible for maintaining confidentiality by never sharing passwords or access and
   always locking or logging off an application, terminal or workstation when leaving an area. Each person is
   accountable for all activity under their password, account and or electronic signature. Such activity may be
   monitored.

   Disclosure of confidential information is prohibited even after termination of employment, contract or any
business agreement/relationship unless specifically waived in writing by an authorized party who has consulted with SBUH Legal Counsel and/or the SBUH Information Security Officer.

I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including, but not limited to co-workers, friends and family members). I understand that this obligation remains in full force during the entire term of my employment/affiliation and continues in effect after such employment/affiliation terminates.

3. Confidentiality Policy

I agree that I will comply with confidentiality policies that apply to me as a result of my employment/affiliation.

4. Return of Confidential Information

Upon termination of my employment/affiliation for any reason, or at any other time upon request, I agree to promptly return to Stony Brook University Hospital or my employer any copies of Confidential Information then in my possession or control (including all printed and electronic copies), unless retention is specifically required by law or regulation.

5. Periodic Certification

I understand that I will be required to periodically certify that I have complied in all respects with this Agreement, and I agree to so certify upon request.

6. Remedies

I understand and acknowledge that:
   a) The restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients, Stony Brook University Hospital and my employer (if different than SBUH); and b) My failure to comply with this Agreement in any respect could cause irreparable harm to patients, Stony Brook University Hospital and my employer.

7. Code of Conduct

I understand that I am responsible for reading and adhering to the ethics and standards of conduct as defined in the SBUH Corporate Compliance Code of Conduct. I am responsible to report any suspected violations of Compliance with the Code of Conduct and I have reported all known violations. I understand in reporting a suspected violation I will not be disciplined or subjected to retaliatory actions for any report that I have made in good faith.

I understand that the University may initiate administrative actions against me in accordance with SBUH HIPAA policies, applicable collective bargaining agreements, federal/state and local government laws for disclosure of or unauthorized use of HIPAA-PHI or e-PHI, employee information, financial information, research information, SBUH business information, or non-compliance with the ethics and standards of the Code of Conduct. I understand that University sanctions or a violation may include, but are not limited to, penalties up to and including termination of employment, contracts and any other business relationship with SBUH. I understand that I may be subject to civil and/or criminal penalties.

I have received and read this Statement of Confidentiality and understand the requirements set forth in it.

Printed Name (LEGIBLY):______________________________________     Date: _____________________

Signature: ____________________________________________________