Authorization to Capture/Use PHI on Portable Devices or Removable Media

Loma Linda University Adventist Health Sciences Center and Core Corporations[*]

Authorization to capture/use PHI (Protected Health Information) on a portable device or removable media is granted to the user identified below based on review and evaluation of the business need. Users must take responsibility for the security of their devices and the information contained in it. A signed copy of this authorization must be given to the authorized user and the original is to be maintained in the user's personnel file.

Note: While accessing network data through use of a VPN does not require the use of this form, the capturing of data obtained as a result of VPN access (e.g., through cutting & pasting, data entry into another computer) requires the use of this form.

Section 1:

This section to be completed by the individual indicated in the Authorizing Signature section below:

Describe the defined business reason:

Temporary storage in computer memory (RAM) while remotely accessing and processing patient information contained in axiUm Dental Management Software via VPN.

Approval Period: *(Office Use Only)*

The approval period must be granted annually or given a specific time period that is **less than one year**.

Approval Period: ☑ Annually ☐ Specific Period: _____ to _____
(If less than one year) Date Date

Section 2: User Agreement

This section to be completed by the authorized user

I understand that I have been granted authorization to capture, ***temporarily*** store, or use PHI on a personally owned or an organization issued portable device or removable media. This authorization has been granted based on a defined business need; therefore, usage must be limited to those uses necessary to meet that business need. I agree to follow the requirements and guidelines as stated in this User Agreement. I understand that all patient identifiers must be used minimally (e.g., using first initial and last name (not full name), using only birth month and day when possible, and city and zip code instead of full address).

At no time will I store Social Security numbers in portable device(s) or removable media.

I agree to use physical and technical safeguards for the protection of my device/media such as ensuring the device/media is securely stored when not in use and never left unattended during use or transport. I agree to use strong password protections as well as to use encryption technology, as commercially available. I will work with IS as necessary to ensure the most effective protection is in place. I will ensure the proper destruction of all PHI from my device/ media immediately after intended use, and I will not use the device/removable media beyond the approval period. If my device/media is lost or stolen, I will immediately report the loss/theft to the IS department even if I believe that I have previously deleted all PHI from it.

I will use the following portable devices to capture/use PHI: ☐ Laptop ☐ PDA ☐ Other: _____
(Specify)

Section 3:

This section to be completed by the authorized user

Entity: _____ Cost Center:_____

Required Signatures

User Name (*Print*): _____ Title/Position: _____

User Signature: _____ Date: _____ ID# _____

Authorized by (Print Name): _____ Title/Position: _____

Authorizing Signature: _____ Date: _____ ID# _____

Authorizing Signature: (For employees, Department Head or Manager; For Residents/Fellows, Director of Graduate Medical Education or Designee; For employed physicians, Practice Corporation President or Designated Administrator; For non-employed physicians, Med Staff President)

*Core Corporations include: LLU, LLUMC, LLUBMC, LLUHC, LLUHS, FP & S, FMG, and other LLU Faculty Practice Plan Groups