Stony Brook Medicine

Community Physician Portal Application Instructions

*****Please note - to use the portal you must have Google Chrome, Firefox, or Internet Explorer 10 (or higher) *****

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

2. Sign all documents, including a copy of your driver's license, and e-mail the completed form to PhysicianOutreach@stonybrookmedicine.edu.

3. Within 4-6 weeks 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 username and password.

For any questions, please call 631-638-INFO (4636)

Stony Brook Medicine

SECTION 1: MUST BE COMPLETED BY ALL- – PLEASE PRINT

Phone number 631-638-4636

Send completed form to PhysicianOutreach@stonybrookmedicine.edu

Section 1

	Last Name	First Name
Name		
Stony Brook ID Number Driver Lic. Number Not needed if you already have a Stony Brook ID Number Copy of Drivers License required for all new accounts	□□□□□□□□□ *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 secure.
*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 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:_____

Stony Brook Medicine

Stony Brook Hospital

Electronic Information Access Confidentiality Acknowledgement Statement

Important: Please read all sections. If you have any questions, please contact the Physician Outreach Office at 631.638.4636 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) For the duration of my affiliation with Stony Brook University Hospital (SBUH), I may be given access to certain Confidential Information that may also require additional protections including but not limited to;

1) The New York State Public Health Law Article 27-F and Part 63 of 10 NYCRR AIDS Testing and Confidentiality of HIV-Related Information; which states that 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; including but not limited to any information indicating 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 fines and imprisonment

2) The New York State Mental Hygiene Law § 33.13 governs the protection, confidentiality and disclosure of behavioral health services, psychiatric care and substance abuse treatment. The law strictly limits disclosure of mental hygiene/health related information. ***All*** disclosures of mental hygiene/health related information require an authorization signed by the patient/individual or their personal representative.

3) The Genetic Information Non-Discrimination Act (GINA) prohibits discrimination in health coverage and employment based on genetic information. The law addresses the confidentiality of genetic test results and prohibits the misuse of genetic information.

4) The Federal Law 42 CFR Part 2 (known as Part 2) Disclosure of Substance Use Disorder (SUD) Patient Records protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 information can be disclosed. In general, the disclosure of Part 2 program patient information requires written consent from the patient.

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

Any information acquired or accessed within the Stony Brook EMR/PACS must be kept confidential. This applies to all Protected Health Information governed under HIPAA and includes patient health and financial information.

Each individual working in the SBUH computer systems environment is responsible for protecting the privacy of the SBUH patients' information (e-PHI governed under HIPAA) and , employee information, financial information, research information and SBUH business information, if applicable 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 systems containing ePHI governed under HIPAA, is permitted on an as needed basis only for the required performance of assigned responsibilities in my role as a health care professional, only as permitted under HIPAA, 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, in my role as a health care professional, 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. I understand that the Physician Outreach Office will verify my employment at least once a year and that I am required to respond, failure to do so will result in termination of access.

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. 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 for reporting 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 PHI or e-PHI governed under HIPAA, 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: _____

To be completed by office manager:

I understand that it is my responsibility to contact the Physician Outreach Office via phone at 631.638.4636 or via email at physicianoutreach@stonybrookmedicine.edu if this employee is no longer employed at my practice so their account may be terminated.

_____

Employee's Name

_____

Office Manager's Name

_____

Office Manager's Signature

_____

Date