Michigan Medicine
Laboratories (MLabs)
2800 Plymouth Rd, Bldg 35
Ann Arbor, MI 48109-2800

734.936.2598 • 800.862.7284 • mlabs.umich.edu
FAX: 734.936.0755

MLabsCONNECT Confidentiality Agreement

This form can be completed and signed electronically
*Email completed forms to **PATH-MLabs-MLC-Users@med.umich.edu** or fax to **734-936-0755***

PROTECTING THE CONFIDENTIALITY AND SECURITY OF PROTECTED HEALTH INFORMATION

MLabs is committed to protecting the confidentiality and security of Protected Health Information (PHI). Access privileges to MLabsCONNECT (MLC) are granted to MLabs client employees for use in performing their job duties as they relate to accessing their patients' laboratory test results. As an MLabs Connect user, I understand that I will be held accountable for compliance with MLabs policies and procedures governing the confidentiality and security of PHI. The following summarizes the standards that MLabs requires me to uphold:

RESPONSIBILITIES

By receiving access privileges to MLC or other information systems (Systems), I understand the following:

- **PHI Access**. I will access only the patient PHI necessary to carry out my job responsibilities and I will treat this PHI in a confidential and secure fashion.
- **Security**. I will not reveal any of my passwords or share access to my user account with others. I will not access Systems using another person's user account. I understand that my access to MLabs' Systems may be audited at any time, with or without cause. I understand that I am responsible for any access that occurs using my password.
- **Portable Devices**. If I use a portable electronic device, such as a laptop, I will ensure that it meets Health Insurance Portability and Accountability Act (HIPAA) security standards and acknowledge that I am responsible for maintaining the security of such information in accordance with HIPAA. If I am unsure whether the device is compliant, I will consult with my supervisor or employer before using such a device.
- **Training**. I have completed and understand the HIPAA training required for my position by my organization or employer.
- **Noncompliance**. I agree to immediately report suspected noncompliance to my supervisor. I will cooperate with any investigation of possible noncompliance and will not withhold relevant information. I understand that unauthorized access, use, or disclosure of PHI may violate federal or state laws and may result in criminal and civil penalties against me personally or against my employer.

ATTESTATION

REQUIRED FIELDS ARE INDICATED WITH AN ASTERISK (*)

By signing this Agreement, I certify that I have read and agree to abide by the standards as stated above.

Printed Name * _____ Title * _____ Phone Number * _____

Date * _____ Signature * _____ Email Address * _____