



OPNS Physician/Office Staff/Health Focus Log-In Application

User Full Name:	
Practice Name:	
Physician Name(s):	
User E-Mail:	
User Position:	
Phone Number:	

Confidentiality Agreement

Please be aware that by signing this document you are acknowledging your commitment to ensure the protection of patient health information and to comply with the Standards of Privacy of Individually Identifiable Health Information pursuant to HIPAA and HITECH guidelines. You should also be aware that an audit trail is maintained of all User ID's accessing these patient information systems and that access is to be limited only to those with a need to know for purposes of patient care, medical record review or quality assurance. Just as a reminder, passwords are never to be shared. In the event of a termination where any of the above mentioned individuals cease employment with your office, please notify **Nasser Nasser** at nnasser@opns.org immediately so that access to PHI is removed and the login information to your data is kept current.

(User Signature)

(Date)

Please scan/email or fax form to: 248-682-6044 Attn: Nasser Nasser