

Lakeside Systems, Inc.

COMPUTING ACCOUNT AUTHORIZATION FORM

STATEMENT OF CONFIDENTIALITY: I understand that it is the Policy of Lakeside Systems, Inc. to respect and maintain the confidentiality of all Confidential Health Information with respect to all patients of Lakeside Systems, Inc. For purposes of this request, patient "Confidential Health Information" shall include without limitation, all Confidential Health Information regarding a patient's: (1) Medical treatment and condition; (2) Psychiatric and Mental Health; and (3) Substance abuse and Chemical dependency, which Lakeside Systems, Inc. Personnel may receive pursuant to their relationship with Lakeside Systems Inc., and shall include without limitation, the following patient identifiable information: (1) Name; (2) Address, including street address, city, county, zip code and equivalent geocodes; (3) Names of relatives; (4) Names of employers; (5) Date of birth; (6) Telephone numbers; (7) Facsimile number; (8) Electronic mail address; (9) Social security number; (10) Medical record number; (11) Health plan beneficiary number; (12) Account number; (13) Certificate/license number; (14) Any vehicle or other device serial number; (15) Web Universal Resource Number (WURL); (16) Internet Protocol (IP) address number; (17) Finger or Voice prints; and (18) Photographic images; and (19) Any other unique identifying number, characteristic, or code that may be available to Lakeside Systems, Inc. Personnel which could be used, alone or in combination with other information, to identify an individual. I understand that in addition to patient Confidential Health Information, during the scope of my employment or other service relationship with Lakeside Systems, Inc., it may be necessary for me to receive, review, and work with certain other confidential and proprietary information of Lakeside Systems, Inc. that may relate to Lakeside Systems, Inc. financial and other business information and/or records regarding Lakeside Systems, Inc's operations, business plans and employees. For purposes of this statement such information and patient Confidential Health Information defined above, are referred to herein collectively as "Confidential Information."

ACCOUNT AGREEMENT: I understand that no Confidential Information may be accessed, discussed, or released without having the proper authorization to do so. Any access, discussions or release of Confidential Information shall only be for purposes of patient care and/or Lakeside Systems, Inc. business and shall be on a "need to know" basis (i.e., in order to carry out the duties necessary for my employment or other services provided to Lakeside Systems, Inc). Access shall also be limited to the "minimum necessary" information to achieve the purpose of the access. Access, disclosure or release includes, without limitation, the access of any electronic or paper-based Confidential Information. (More specifically stated in signed Lakeside Systems, Inc. Confidentiality Statement) I further understand that I will be issued a unique Username and Password which I will keep confidential and will not reveal to anyone, and that if I discover that the confidentiality of my Password has been compromised, I will change it immediately and promptly notify EIS Data Security. By indicating my signature below, I attest that I have reviewed and understand the foregoing statements and agree to be bound by the terms and conditions herein and the relevant Lakeside Systems, Inc. policies and procedures regarding computer usage and confidentiality, and that any failure on my part to comply with the terms set forth herein and in such policies will subject me to disciplinary action which may include immediate termination of my employment and/or legal action as deemed appropriate.

All fields must be completed or the request will be returned.

Last Name: _____ First Name: _____ MI: _____
PLEASE PRINT CLEARLY PLEASE PRINT CLEARLY

Mother's Maiden Name*: _____ Employee Job Title: _____

*An Alternate name can be listed for security purposes

Office/Location: _____ Telephone#: () _____ Fax: () _____

Department/Division: _____

Group or Physician(s) Name: _____

Group or Physician(s) Tax ID Number: _____

Supervisor's Name: _____ Job Title: _____ Phone#: () _____

Supervisor's Email: _____

Requestor's Signature: _____ Date: _____

COMPUTING ACCOUNT AUTHORIZATION FORM (cont'd...)

TYPE OF SERVICES REQUESTED

- New Account
 - Change Account
 - Terminate Account Effective Date: _____

 - Name Change From: _____ To: _____
- Security Training completed on: _____

TYPE OF ACCESS REQUESTED

Select the type of access desired:

- View Claims
- View Authorizations
- Create Authorizations

Select the groups you would like to access:

- Community Medical Group
- Eastland Medical Group
- Korean American Medical Group
- Lakeside Medical Group
- Verdugo Hills Medical Group
- West Covina Medical Group

Fax the completed form to: (818) 707-1303

The new account username and password will be emailed to the Supervisor.

If you any questions, please contact the MIS dept. at (818) 707-9603. Thank you.

Privacy statement: All personal information on this request will be treated in strict confidence and will be available only to those Lakeside Systems, Inc. staff who need the information to conduct Lakeside Systems, Inc. business. They will not be shared with any other parties within and outside of Lakeside unless required by Lakeside business.

For Lakeside Systems, Inc. Use Only

User ID: _____

Date Completed: _____

Completed By: _____