Confidentiality and Information Security Acknowledgement

I have read the Confidentiality Policy, Computer Use and Security Policy, and the Information Security Agreement. I understand my responsibilities and will abide by all the provisions identified.

Provide the name and signature of individual needing access.

Print Name Clearly _____

Last 4 digits of SS# _____ Birth Month _____ Birth Day _____

Signature _____ Date _____

Check the box that applies and provide the remaining information.

☐ Physician CDH Dr. # _____

Practice Name _____

Partner Name (1) _____

☐ Physician Office Staff

Office Manager _____

Office Manager Email Address _____

Office Phone Number _____

Practice Name _____

Practice Address _____

Primary Physician Name _____

☐ Contractor / Temp Worker / Vendor

Company Name _____

CDH Supervising Manager _____

CDH Department Name _____

☐ Student

Circle Type: Nursing Rehab Pharmacy Other _____

School Name _____

CDH Supervising Manager DAVID ESTERQUEST, BSW

CDH Department Name Manager EMS / Trauma / Emergency Management

☒ Other EMT - Paramedic

- **FAX completed form to 630-933-2588 - the "Provisioning Group"**
- **Then call either Lisa Crank @ 630-933-1193 or Jennie Bernaden @ 630-933-6773 when faxed.**

For CDH Use Only

Provision _____ Provision Date _____ UserID _____

Circle One: Clinical Portal MSO/Billing Research August 2009