

Exhibit 1

User Confidentiality Agreement

This form must be reviewed and signed by each User requesting access to the
EpicCare Link system.

CHRISTUS Health (“CHRISTUS”) agrees to grant me access through CareLink to the ConnectCare electronic medical record system, only in full compliance with and fully subject to the conditions of the Agreement and the terms set forth below. I agree to the following provisions:

1. If I am a physician, I agree to provide my NPI number where indicated below. I further agree that should my ability to practice medicine in the state of which I am licensed (as listed with my NPI) be restricted in any way, I will notify CHRISTUS of such restrictions immediately, and I understand that my access to the electronic medical record may be revoked or restricted, at the sole discretion of CHRISTUS.
2. I acknowledge that by accessing the electronic medical record or a portion thereof, I may obtain confidential patient and clinical information including but not limited to the electronic medical record in whole or in part, (“Confidential Information”), and I agree to comply with all existing and future CHRISTUS policies and procedures concerning the security and confidentiality of Confidential Information. I agree that I will not save Confidential Information to portable media devices (Floppies, ZIP disks, CDs, PDAs, and other devices). I agree to safeguard my tokens, user ID, or passwords and agree that I will not write down my user ID and password on the same piece of paper or otherwise place such user ID or password in an area where it may be intercepted. I agree that I will not release my tokens, user IDs, or passwords to any other person, including any employee or person acting on my behalf. I agree not to allow anyone else to access electronic medical record under my tokens, user IDs, or passwords. I agree not to use or release anyone else’s tokens, user IDs, or passwords. I agree to notify the CHRISTUS EpicCare Link Support Desk at (903) 606-7850 immediately if I become aware or suspect that another person has access to my tokens, user IDs, or passwords or I have lost my token. I agree not to allow any unauthorized person to use or access the Confidential Information and electronic medical record either onsite or remotely. I agree not to allow my family, friends or other persons to see the Confidential Information on my computer screen while I am accessing the electronic medical record. I further agree to fully log out of the electronic medical record before leaving my workstation.
3. I agree to follow all CHRISTUS policies and procedures concerning access, use and disclosure of patient health information. I agree to access Confidential Information only for those individuals with whom I or the physician(s) for whom I work have a treatment relationship. I also agree to access only the amount of Confidential Information necessary to perform my job functions related to that treatment relationship. I agree that I am strictly prohibited from accessing non-patient Information and shall hold CHRISTUS fully harmless from any damage related to such unauthorized access. Any other access requires the express permission of CHRISTUS.
4. I agree that I will never access Confidential Information for “curiosity viewing” or “surfing” patient records. I understand that this includes viewing the Confidential Information of my children, other family members, friends, or coworkers, unless access is necessary to provide services to patients with whom I or the physician(s) for whom I work have a treatment relationship.

5. I agree that CHRISTUS may audit my compliance with this Agreement.

6. I agree that my obligations under this Agreement will continue in the event that CHRISTUS terminates my access to the electronic medical record under this Agreement.

7. I agree that if I breach any provision of this Agreement, CHRISTUS has the right to terminate my access to the electronic medical record immediately. I understand that, if I have credentials at a CHRISTUS facility, any breaches may be referred to the peer review process as a breach of confidentiality as defined in the Bylaws of the Professional Staff or the Disciplinary Action Policy at CHRISTUS's discretion. Furthermore, any breach of these provisions may result in civil or criminal action taken against me, including the assessment of applicable penalties as it relates to such breach.

User signature: _____

Name (**FIRST MIDDLE & LAST**): _____

Title (MA, LVN, RN, MD, DO, NP, etc.) _____

NPI (Provider ONLY put NA if non provider): _____ State of License _____

DOB: (mm/dd/yyyy): _____

Last four digits of Social Security: _____

Personal phone number (Used for Two-factor authentication): _____

User work email address: _____

Date: _____

Is this office a **surgeon's office** that will **perform procedures at CHRISTUS**? _____

Will this user need **access to obtain consents** for procedures at CHRISTUS? _____

Current CHRISTUS ID (If applicable): _____

Closest CHRISTUS Hospital: _____

Site Name (Full Name for validation): _____

Do you currently work in a CHRISTUS Facility? _____