

BYOD Registration Form

| Device Owner Name: | | |
|---|---|---|
| Date: | | |
| Device Description: | | |
| may not come into contact regarding our clients. To m | l device within my work duties and my device may with PHI and be a source for safety and security is itigate unethical or unsecure behavior, I am naking sure it meets the security standards set by | |
| An audit of the device's sed documented below. | urity measures has been performed, and is | |
| Auditor: Name of auditor: | | |
| Primary Intended Use*: | | |
| e-fax, VoIP app, etc.,) or pe | tice services (i.e. email, practice management system forming practice functions (i.e. calling or texting values are cards/client info, creating and/or storing | |
| Operating Software Versi | on: Most Recent Version?: Y / I | N |
| Technical Measures (if the device, check N/A): • Encrypted (full device) | e technical measure is not applicable to your | |
| □ Antivirus Active | □ N/A | |
| □ Firewall Active | □ N/A | |
| Password is strong | □ N/A | |

| Set to log out after idle time Tracking software is active Has a user account just for doing | □ N/A | □ N/A | |
|--|---|--------------|--|
| Backup Strategy For This Device: (or explain why it's not needed): | | | |
| | e, currently satisfies the requirements ocedures, including the Bring Your Ov | | |
| will need to be properly retired f | l no longer be used in a clinical setting, t from use. This retirement process may in g that no sensitive information still is he | nclude | |
| | es and procedures of Mind Body Wellne the Bring Your Own Device Policy. I hav cy and understand its contents. | | |
| Signature of Device Owner: | | | |