BYOD Registration Form

Device Owner Name: _____

Date: _____

Device Description: _____

I will be using this personal device within my work duties and my device may or may not come into contact with PHI and be a source for safety and security issues regarding our clients. To mitigate unethical or unsecure behavior, I am registering my device and making sure it meets the security standards set by Headway Therapy.

An audit of the device's security measures has been performed, and is documented below.

Auditor: Name of auditor:

_____

Primary Intended Use*:

_____

*e.g. such as accessing practice services (i.e. email, practice management system, e-fax, VoIP app, etc.,) or performing practice functions (i.e. calling or texting with clients, taking photos of insurance cards/client info, creating and/or storing documentation/records.)

Operating Software Version: _____ Most Recent Version?: Y / N

Technical Measures (if the technical measure is not applicable to your device, check N/A):

▢ Encrypted (full device) ▢ **N/A**

▢ Antivirus Active ▢ **N/A**

▢ Firewall Active ▢ **N/A**

▢ Password is strong ▢ **N/A**
▢ Set to log out after idle time ▢ **N/A**
▢ Tracking software is active ▢ **N/A**
▢ Has a user account just for doing Headway Therapy business ▢ **N/A**

Backup Strategy For This Device: (or explain why it's not needed):
_____

The device, as described above, currently satisfies the requirements of Headway Therapy's policies and procedures, including the Bring Your Own Device Policy: Y / N

If, at a later date, this device will no longer be used in a clinical setting, this device will need to be properly retired from use. This retirement process may include properly removing and verifying that no sensitive information still is held in the device.

I agree to comply with the policies and procedures of Headway Therapy with regards to this device, including the Bring Your Own Device Policy. I have read the Bring Your Own Device Policy and understand its contents.

Signature of Device Owner: _____