Athena Credit Card Processing Privilege Form

By signing the line below, I acknowledge that SOM IT and UTRGV has fully and duly informed me of the potential for misuse and abuse of credit cards or credit card information that may be collected from patients either through walk in or the telephone. I will be responsible for educating the employee of the consequences of misuse and abuse of credit card information.

(by initialing, I acknowledge and agree to the following statements)	***Initials:***
1. I will securely delete or shred card holder data when no longer needed for legal, regulatory, and/or business reasons in Athena at the end of the business day.	
2. I will not retain credit card information beyond clinic requirements and patient authorization.	
3. I will not store the card verification code or value (three-digit or four-digit number printed on the front or back of a payment card) after authorization in Athena.	
4. I will destroy, all available cardholder data so that it cannot be reconstructed in Athena or any other platform.	
5. I will ensure storage containers used for credit card information will be secured to prevent access to the contents.	
6. I will ensure that all utilized Athena credit card devices are inspected daily to look for tampering or substitution.	
7. I will escalate, in a timely and effective way, technical issues with the Athena credit card machine with the SOM IT staff only.	

***Please note that it may take up to 2 business days for your request to be processed.*

Name:_____Employee ID:_____Phone:_____

Email:_____Athena Username:_____

Signature:_____ Job Title: _____

Supervisor Signature

Printed Name:_____Signature:_____Date:_____

Non-UTRGV Employees

- Copy of government issued photo ID required
- Sponsorship by Senior Director of Clinical Operations or Senior Director of Clinical Administrationrequired

Senior Director of Clinical Operations
Printed Name:_____ Signature:_____Date:_____

Senior Director of Clinical Administration
Printed Name:_____Signature:_____Date:_____