Epic Security Individual Access Request Form

[This is for an individual / employee of a clinic to request access]

User Agreement			
This form must be complete by each individual user. Each individual user must register to receive his/her own password. Passwords cannot be shared.			
☐ New ☐ Change ☐ Delete ☐ Physician ☐ Physician Staff ☐ Other ______________________			
Individual User Access Information			
First Name:	Middle Initial:	Last Name:	**<u>List Any Existing User IDs:</u>**
<u>Practice Name:</u>	Practice Street Address:		
City:	State:	Zip:	
E-mail Address:	Position Title:		
Credentials:	DEA Number:		
Specialty:	Office Phone Number:		
Supervising Physician's PRINTED Name and Signature:	Physician's ID Number (Providence): * Also known as dictation number		

User Security Question (Select a password reset question by checking the box below and providing the answer in the column to the right)		
☐ What is your mother's maiden name?	☐ What is your date of birth?	
☐ In what city were you born?	☐ What is your favorite restaurant?	
☐ In what year did you graduate high school?	☐ What is your favorite animal?	
☐ What was your high school mascot?	☐ What is your favorite book?	

<u>Please check all items required</u>:

- ☐ Remote Access (myweb.provak.org REQUIRES KEYFOB – CHECK IF NEED KEYFOB)**
- ☐ Remote Access (KEYFOB ALREADY IN POSESSION)
- ☐ Network Access + email (PHSA Contract Physicians Only)

Please select either Hyperspace or Epic Care Link and then identify the role of the user.

☐ Access to Hyperspace	☐ Access to Epic Care Link	☐ Access to ProvPort
☐ Physician / PA / ANP	☐ Front Desk	☐ Access to Synapse (View Radiology Images)
☐ Nurse in a surgical office	☐ Biller / Coder	
	☐ Site Administrator	
	☐ Non-surgical office nurse / MA	
	☐ Other	

** Remote access for physician *office staff* is limited to 6 a.m. – 7 p.m. Monday – Friday. Any additional hours must be approved.

User Signature:

The information I have filled out above is correct and I have signed the User Agreement:

______________________________ ____ ____________

Print User's Name User's Signature Date

Authorized Agent's Signature

The information I have filled out above is correct and I have signed the User Agreement:

______________________________ ____ ____________

Print Authorized Agent's Name Authorized Agent's Signature Date

- PLEASE RETURN VIA FAX TO: (907) 212-5616 -

Exhibit B
Terms & Conditions of Use

The protection of health and other confidential information is a right protected by law and enforced by fines and criminal penalties as well as policy. Safeguarding protected health information is a fundamental obligation for all persons accessing it. Signing below will commit you to that obligation, and WILL be used as proof that you understand and agree to the stated basic duties and facts regarding privacy.

Signing this form indicates the following:

1. ____ I agree to protect the privacy and security of confidential information I access through Providence's electronic records at all times.

2. ____ I agree to a) access confidential information to the minimum extent necessary for my assigned duties and b) disclose such information only to persons authorized to receive it.

3. ____ I understand the following:

a. ____PROVIDENCE HEALTH & SERVICES ALASKA ("Providence") tracks all user IDs used to access electronic records. Those IDs enable discovery of inappropriate access to patient records.

b. ____ Inappropriate access and/or unauthorized release of confidential or protected information will result in disciplinary action, up to and including termination of employment, and will result in a report to authorities charged with professional licensing, enforcement of privacy laws and prosecution of criminal acts. I further understand and agree that inappropriate access and/or unauthorized release of confidential or protected information may result in temporary and/or permanent termination of my access to Providence electronic records.

c. ____ That I will be assigned a User ID & a one-time use activation code. I agree to immediately select and enter a new password known only to me. I understand I may change my password at any time, and will do so based on Providence established policy and/or when prompted. I understand that I am to be the only individual using and in possession of my confidential password. I am aware that the User ID and password are equivalent to my signature. Also, I am aware that I am responsible for any use of the system when accessed utilizing my User ID and password. This includes data entered, viewed, printed or otherwise manipulated. If I have reason to believe that my password has been compromised I will report this information to Providence and I will also immediately change my password. I understand that User IDs cannot be shared. Inappropriate use of my ID (**whether by me or anyone else**) is **my** responsibility and exposes me to severe consequences.

4. ____ I understand that confidential health information includes but is not limited to: Any individually identifiable information in possession of or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patient's and/or his/her family member's records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Centralized and/or department based computerized patient data and alphanumeric radio pager messages;

5. ____ I understand confidential employee business information that is not available in the public domain includes but is not limited to:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from Providence's records, which if disclosed, would constitute an unwarranted invasion of privacy; or disclosure of protected or confidential information that would cause harm to Providence.

Signature: ____

Print Name: ____

Date: __________________________