

Computer System Access Request Form



REQUESTING USER INFORMATION

First _____ M.I. _____ Last _____ Last 4 Digits SSN _____

Job Title _____ Phone _____ Ext. _____

Department _____ Date _____

Regular Temporary Employee Vendor If temporary employee or vendor, record anticipated signon deletion date:
Note: The Department Manager is responsible for notifying the appropriate System Administrator when contracted/temporary personnel no longer need system access and what access the temporary/contracted personnel have that should be deleted.

AUTHORIZATION

Manager/Supervisor Signature _____ Print Name _____

Phone _____ Fax _____ e-Mail _____

SYSTEM

Access to: Fairview Lakewood Lutheran
 Action: Add new access Change existing access* Delete access*

* Please complete a new form to authorize a change or deletion of access. If changing access, please include previous information (department, signon, etc.) in Special Instructions

Requesting access to: _____ **Model after:** (Provide signon or name of a person who currently has the same access as what is needed)

- Clinical Orders/Results/Registration
- Network
- E-Mail
- Patient Accounting
- Other:
- Other:
- Other:
- Other:

Special Instructions

STATEMENT OF CONFIDENTIALITY

During the course of my employment by the CCHS Western Region

- I will have access to confidential information concerning patients and/or the hospital's business, finances and employees. This information may be in the form of verbal, written or computerized data. I have a legal obligation to keep confidential all information concerning patients and business data that I may have access to and will only discuss information with employees who have a **need to know** in order to perform their job. This information will remain confidential regardless of my employment status at this institution.
- The acquisition, release, discussion, or other use of confidential information, including patient information and confidential business data, for purposes other than that which is required of my job, is strictly prohibited
- I understand that any unauthorized access, release, use or possession of confidential information **may result in termination and/or legal action** against my employer or me.
- In addition, by accepting a sign-on/password for the CCHS Western Region Health Information System, I also understand:
- I have a legal obligation to keep confidential **all information concerning patients and confidential business data** that I may have access to and will only discuss information with employees who have a **need to know** in order to perform their job.
- I will not intentionally attempt to gain access to areas that are not needed for the performance of my job.
- The sign-on/password that is assigned is unique to me and is **not transferable**.
- I am accountable for any information entered in the system or information accessed by any person under my sign-on/password, therefore I will notify my Supervisor and/or the System Manager (or designee) immediately if I suspect that someone has gained unauthorized access to my sign-on/password. I will also change my password(s) so that further unauthorized access is not possible.

I agree to be bound by the Statement of Confidentiality above. I understand my obligation to maintain confidentiality and my responsibilities regarding the use of the health information system, as well as the consequences for failure to do so.

Signature (Employee) _____ Date _____

ITD USE ONLY: HEAT Number: _____ Date Completed: _____ Completed By: _____