**Carson Tahoe Health System CTRH IT USE ONLY**

**User ID Request Form – Non CTHS Employee Date Received:** Click here to enter a date.

**This form to be used for User ID Requests of Non-CTHS Employees Only! Ticket #:** Click here to enter text.

**NOTE: Must submit this form with a signed Statement of Confidentiality**

**\*\*\*Access Applicant Information\*\*\* \*Required Field**

**\*Name:** Click here to enter text. **\*Title:** Click here to enter text. \***E-Mail Address:** Click here to enter text.

**\*Entity/Department/Billing Service/Physician Practice:** Click here to enter text.

**\*Telephone Number:** Click here to enter text.

Former CTHS Employee? ☐YES ☐NO User setup should be identical to those of: Click here to enter text.

User has had a name change? ☐ Former Name: Click here to enter text. New Name: Click here to enter text.

**Please note that both the Authorizing Person and the Access Applicant will receive a secure email with the new user’s credentials once the account has been created. Please allow a one week turnaround time**

**\*\*\*Access Requested\*\*\***

☐ ChartMaxx ☐ MR12 (Formally DX) ☐ SCM ☐ eClinicalWorks ☐STAR/HBO GUI

☐CTH User Account/Terminal Server ☐ HSM/PHS ☐ EMon ☐ HRM/MRM

**\*\*\*Management Staff or Physician Authorization\*\*\***

I understand as the Authorized Representative acting on behalf of the Entity noted above, I am obligated to promptly report the separation of the afore documented Applicant to the CTHS Helpdesk at (775) 445-8929. Failure to do so may subsequently inhibit access to CTH systems by this entity.

**\*\*Access Applicant and Authorizing Management Staff or Physician cannot be the same person.**

**\*\*Requests submitted where the Access Applicant is also documented as the authorizing person will not be processed.**

**\*\*Access is granted for no more than a one year term.**

**\*\*A new Access Request form will be required annually.**

**\*\*Physician approval is required for SCM computer physician order entry (CPOE). Per CMS Meaningful Use Guidelines, only a licensed healthcare professional and/or an individual certified in Medical Assistance can perform CPOE on behalf of a Physician.**

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

**\*Check the box below**

☐ By checking this box and typing my name below, I am electronically signing this application.

**\*Name of Authorized Signature**: Click here to enter text. **\*Title:** Click here to enter text. **\*Date:** Click here to enter a date.

**\*Telephone Number:** Click here to enter text. **\*Fax Number:** Click here to enter text. **\*E-Mail Address:** Click here to enter text.

**Reason for access request:** Click here to enter text.

**Comments/Additional Software/Applications:** Click here to enter text.

**Carson Tahoe Health System**

**NON-EMPLOYEE/ SERVICE PROVIDERS**

**STATEMENT OF CONFIDENTIALITY**

I understand that the information that I will access through all Carson Tahoe Health System computer systems and manually generated records include sensitive and confidential patient information. I understand that it is my responsibility to maintain confidentiality of all information, both clinical and financial, entrusted to me.

I specifically understand that information regarding patients, employees and individuals affiliated with Carson Tahoe Health System is to be disseminated to only those individuals who have a need to know.

I agree to access information only on patients for whom I need to fulfill my project/service related responsibilities.

I understand the user ID/password assigned for access to any Carson Tahoe Health System Computer Systems is unique to me/service provider and for my use only. This code identifies me in the computer system. I am accountable for system access and entries performed with the security code.

I agree not to release the password assigned to anyone else. Service providers agree to release the password only to those employees on a need-to- know basis for the sole purpose of the project/service provided. I will not post, share or otherwise distribute the password. I will contact the Information Technology Department of Carson Tahoe Health System immediately if I have reason to believe the confidentiality of the password has been broken. I will be required to create a new password.

Having been allowed remote access to Carson Tahoe Health System Computer System, I will be held responsible for any violations of the above statements by any of my employees who have been given access to the computer systems.

I understand that any violation in patient privacy pursuant to the Health Insurance Portability and Accountability Act (HIPAA) are subject to breach notification rules which include, notification to the patient and Health and Human Services, Office of Civil Rights. I understand that HIPAA violations may also have criminal and civil penalties.

By entering the information below, I acknowledge that I have read the above and accept the responsibilities associated with these statements. I understand that violation of any of the above agreed upon statements may result in immediate termination of my privileges to access the Information System.

Name: Click here to enter text. Date: Click here to enter a date.

Company Name (if applicable): Click here to enter text.

Address: Click here to enter text.

City: Click here to enter text. State: Click here to enter text. ZIP Code: Click here to enter text.

☐ By checking this box and typing my name below, I am electronically signing this application.

Signature: Click here to enter text.

Witness: Click here to enter text.

Once the form is completed, please email in original Word (.docx) format:

To: [helpdesk@carsontahoe.org](mailto:helpdesk@carsontahoe.org)

Subject: Access Request