Meditech Access Request Form

PLEASE FILL IN ALL BLANKS ☐ **NEW USER ACCESS** ☐ **MODIFY EXISTING USER ACCESS**

Name ______________________ Initals ________

Dept/Unit ______________________

Job Title ______________________

Check requested menu access below or copy access from user noted here: ______________________

- ☐ *ABS/ABSTRACTING*
- ☐ *ADM/ADMISSIONS*
- ☐ *AP/ACCOUNTS PAYABLE*
- ☐ *ARM/AUTHORIZATION & REFERRAL*
- ☐ *BAR/BILLING*
- ☐ *HUB/ENTERPRISE MEDICAL RECORD*
- ☐ *ESS/EXECUTIVE SUPPORT SYSTEM*
- ☐ *GL/GENERAL LEDGER*
- ☐ *HR/HUMAN RESOURCES*
- ☐ *ITS/MEDICAL IMAGING*
- ☐ *LAB*
- ☐ *MIS*
- ☐ MM/MATERIALS MANAGEMENT
- ☐ MRI/MEDICAL RECORDS
- ☐ NPR/REPORT WRITER
- ☐ OE/ORDER ENTRY
- ☐ PCS/PATIENT CARE SYSTEM
- ☐ PCM/PHYSICIAN CARE MANAGER
- ☐ PHA/PHARMACY
- ☐ QM/QUALITY MANAGEMENT
- ☐ SCA/SCANNING AND ARCHIVE
- ☐ SCH/SCHEDULING
- ☐ SS/STAFFING AND SCHEDULING

Complete this form and submit both pages to the IS Department.

______________________ ______________

SUPERVISOR SIGNATURE DATE

Confidentiality and Security Agreement

I understand that the facility or business entity (**Dorminy Medical Center**) in which or for whom I work, volunteer or provide services, or with whom the entity (**Dorminy Medical Center**) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (**Dorminy Medical Center**), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, **Dorminy Medical Center** must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information"). In the course of my employment / assignment at **Dorminy Medical Center**, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with **Dorminy Medical Center** Privacy and Security Policies, which are available on the Company intranet .

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with **Dorminy Medical Center**.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to **Dorminy Medical Center**.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with**Dorminy Medical Center**.
8. I will act in the best interest of **Dorminy Medical Center** and in accordance with its Code of Conduct at all times during my relationship with**Dorminy Medical Center**.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within **Dorminy Medical Center**, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using **Dorminy Medical Center** information systems. **Dorminy Medical Center** may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will: a. Use only my officially assigned User-ID and password. b. Use only approved licensed software. c. Use a device with virus protection software.

15 I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect to unauthorized networks through the systems or devices.

16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or **Dorminy Medical Center** information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to **Dorminy Medical Center** at the time of each access that I have the requisite business need to know and appropriate consent, and **Dorminy Medical Center** may rely on that representation in granting such access to me.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

______________________________ ________________

EMPLOYEE SIGNATURE DATE