{Insert Practice Name Here}

Security Login Account Form

Instructions: Fill out form, obtain signature from Office Manager / Practice Liaison, Return to {Insert name here}.

[ ] New Request [ ] Revise Security [ ] Name Change* [ ] Termination

User Name: _____, _____ _____
(Last) (First) (MI)

*Change Name to: _____, _____ _____
(Last) (First) (MI)

Practice Name: _____, Location: _____

Job Title: _____, Phone#: _____

I hereby request access to electronic systems and I have read and understand the policies related to the use and operation of the eHealth Record (EHR) and the eHealth Summary. These polices, as well as others that may have been provided to me are designed to protect the rights of our patients, as well as the practice and its employees. I understand that I am legally bound to these policies as well as all State and Federal laws. As a condition of my employment, I understand that failure to comply with these polices or any State and Federal regulations could result in strict disciplinary action against me, up to and including termination of employment and/or legal action.

User Signed: _____, Date: _____

Office Manager or
Practice Liaison: _____
(Please Print)
Office Manager or
Practice Liaison: _____, Date: _____
(Signature)

Level of access (please check one):

[ ] Level 1 – Administrative (front office), includes Registration, Scheduling, Insurance, Billing. ***No clinical information access.***

[ ] Level 2 – All above, plus clinical information access, including Medical Records, Prescriptions, Vitals, Problems, Refill Requests.

OFFICE USE ONLY

Date Entered: _____ By whom: _____

Confidentiality Form Signed (Y/N)?: _____ Notification Date: _____