HURLEY MEDICAL CENTER

Patient Electronic Information System(s)
Sign-On Code Agreement

HIPAA Health Insurance Portability & Accountability Act

(*) INDICATES REQUIRED FIELDS

* **I am requesting a Sign-on Code for the_____System.**

* Last Name: _____ * First Name: _____ Middle_____

* Previous Name (Maiden Name): _____

* Date of Request: _____* Job Title: _____

* Dept. / Location / Office: _____

* SSN (last 4 Digits): ___ ___ ___ ___ * Birth Date (**/**/****) ___ ___ /___ ___ / ___ ___ ___ ___

* Your Phone#: _____

* Email Address: _____

*(PHOTO ID REQUIRED IF EMPLOYED OUTSIDE HURLEY)

(Authorized signature required)

* Sign-on Approved by: (Sign) _____

* Sign-on Approved by: (Print) _____

* Date: _____ Phone: _____

Authorizing agent and / or user is required to notify Hurley Medical Center whenever a change in work assignment may affect current access code eligibility. (810-262-9766)

Reason for request: New User ___ New Provider ___ Reactivation ___ Additional Code ___

User Access Special Requests (Optional): _____

I should never share my sign-on codes nor allow others access to any information under my sign-on codes. Violation of these rules could lead to termination of access to patient electronic information system(s).

* Initials: ____

* Employee Signature: _____

* Employee Name (Print) _____

NO CODE WILL BE ISSUED WITHOUT COMPLETION OF HURLEY CONFIDENTIALITY FORM / BA AGREEMENT, AND IF APPLICABLE APPROPRIATE HIPAA HEALTHSTREAM MODULES.

General

Codes will be issued with specific user type based on job description/ classification and area of assignment unless otherwise requested in writing by supervisor.