Information Technology
Physician Systems Access Request

Personal Information
Please fill out ALL sections – write N/A if inapplicable

Date ______________

First Name ________________________________

Last Name ________________________________

Title ________________________________

Group ________________________________

Office Phone ______________________

Address ________________________________

Email ________________________________

Applications Requested

- ☐ DI / ehim
- ☐ OPUS MD
- ☐ Oblink
- ☐ PACS
- ☐ Other ________________________________
- ☐ Other ________________________________
- ☐ Other ________________________________

All Office Staff must have an accompanying Physician signature before access will be given to any system at St Mary's Regional Medical Center.

Please return this form to the Information Systems department or Fax to 580-548-5039

If you have any questions please call the Information Systems Helpdesk @ 580-249-3853

I.S. use only

SAR# ____________

DI /ehim ____________

OPUS MD ____________

Oblink ____________

PACS ____________

Other

IS Approval ____________________

Confidentiality Statement for User Access

I UNDERSTAND THAT:

1. My computer password is my own individual, personal code for gaining access into an application or network resource.
2. All patient information is considered confidential medical information and is subject to all standards and policies concerning confidential information.
3. My computer password legally acts as my personal signature when performing all computer activities and as such, is legally binding.
4. All passwords must be a minimum of 4 characters.
5. The information I access from St Mary's Regional Medical Center (SMRMC) Information Systems is confidential and is to be used only in the performance of job-related activities.
6. I am responsible for notifying the information systems department in the event that my password is lost or its confidentiality has been breached, so that we may take appropriate action.
7. I am responsible for notifying SMRMC should I undergo a name, department or job classification change so that my password can be kept accurate. Please notify SMRMC IS of any terminations.
8. If I share my password, use someone else's password or fail to comply with the above hospital policies, I will be committing a breach of hospital policy.
9. I agree to access information only for the purpose related to the performance of my job. The company has the right to randomly audit any information accessed by any user of any information, including e-mail messages sent or received. Failure to Comply with the above will result in disciplinary action.

Electronic Signature Statement

My user name will be stored electronically with each entry.

That it is my responsibility not to reveal my password or PIN number to anyone else for any reason and that I am responsible for any action occurring under my password or PIN number.

That no other person will be allowed to use or "proxy" for me in any manner by using my electronic signature.

That any sharing of my password or PIN number with another individual is a severe breach of security with legal ramifications.

That I have been fully trained in the use of the electronic signature system and I assume full responsibility for keeping my password and PIN number secure and confidential.

Employee Signature: ________________________________ Date: ____________

Physican's Signature: ________________________________ Date: ____________

Ver 07-1-08