INFORMATION ACCESS REQUEST FORM

PLEASE SUBMIT THIS COVERSHEET WITH ALL ACCESS REQUESTS-BOTH NEW IDS AND UPDATES

Please complete all of the information below. Incomplete forms will be rejected.

TODAY'S DATE: ________________ **START DATE:** ______________

USER'S NAME: ____
LAST NAME FIRST NAME MIDDLE INITIAL

LAST 4 DIGITS OF THE USER'S SSN: _________________________

DEPARTMENT NAME: ____

NETWORK USER ID: ____

EMPLOYEE'S TITLE: ____

PRIMARY WORK LOCATION: ____
(UH, UHCD, UFHCN, UFHCNW, UFHCSW, UFHCSE, UHBC, UCCH, DHCS, UTHSC, CTRC, UPG, ETC.)

RC NUMBER: ______________

PHONE/PAGER NUMBER: ________________________ **EXT.**_________

CREDENTIAL: __________ (MD, PA, MS3, MS4, RN, CRRT, LVN, etc.)

PROVIDER ID#:______________**DEA#:**__________________**DPS#:**____________________**State Lic #:**___________________

HOUSESTAFF DEA#: AM1472579 ___ ___ ___ ___ ___ **DPS#: 10046768** ___ ___ ___ ___ ___ **State Lic #:**_______________

☐**FACULTY** ☐**HOUSESTAFF/RESIDENT** ☐**Military Rotator (**__________**to**___________**)**

☐**ALLIED HEALTH W/** ☐ **PRESCRIPTIVE AUTHORITY**

☐**Visiting Medical Student (**____________**to**____________**) Authorization letter from UT Registrar's office must be attached. Requests without authorization will be rejected.**

☐ **Contract/temporary (**______________**to**___________**)**

☐**Researcher or** ☐**Research Monitor (**_______________**to**_________________**) for IRB#**______________________

AUTHORIZATION:
(DIRECTOR/SUPERVISOR)

PRINT:____
NAME TITLE

SIGNATURE:____

E-MAIL ADDRESS FOR NOTIFICATION: ____
(not required if your email is @uhs-sa.com)

Have any questions? Call Data Security at **(210) 358-0640**. You can scan and email completed access requests to DataSecurityScannedRequests@uhs-sa.com, fax them to **(210) 702-4010**, or route them to us at **MS124-1**.
Rev. 07/14

INFORMATION ACCESS REQUEST FORM
EPIC ACCESS

USER'S NAME: ____________________

NETWORK LOGIN ID: ____________

SUPERVISOR'S SIGNATURE: ___________________________________

☐ **ISSUE NEW ID** ☐ **UPDATE EXISTING ID** ☐ **DELETE EXISTING ID**

SELECT THE APPROPRIATE:

☐ **Review Only (Can review charts but not edit data)**

☐ **Review Only with Reporting (Can review charts but not edit data; report access)**

☐ **Coder** ☐ **Billing** ☐ **MedData** ☐ **DataSearch** ☐ **Trend** ☐ **Optum**

☐ **UT Surgeon Clinical Support Staff** ☐ **UT Surgeon Administrative Support Staff**

☐ **IR Radiologist** ☐ **Radiologist** ☐ **Breast Imaging Radiologist**

☐ **Radiology Physician Assistant** ☐ **Cardiology Nurse** ☐ **Cardiology LVN**

☐ **Cardiology MA** ☐ **Cardiology Clinic Scribe** ☐ **Cardiology Practice Manager**

☐ **Cardiology Practice Supervisor** ☐ **Cardiology Benefits Coordinator** ☐ **Front Desk**

☐ **Referral Coordinator** ☐ **Concierge/Greeter** ☐ **Ophthalmology Tech**

☐ **Ophthalmology Clinic Manager** ☐ **Ophthalmology Front Desk** ☐ **Sr Admin Asst**

☐ **Admin Assist** ☐**Data Coordinator** ☐ **Nurse Coordinator** ☐ **Transplant Biller**

☐ **South Texas Renal Group** ☐ **Texas Liver Institute** ☐ **CFL** ☐ **Oncology Nurse**

☐ **Orthotist/Prosthetist** ☐ **Emergency Service Project Manager**

☐ **Medical Student** ☐ **Nurse Practitioner Student** ☐ **Nursing Student**

☐ **Pharmacy Student** ☐ **Physical Therapy Student** ☐ **Occupational Therapy Student**

☐ **Speech/Language Pathology Student** ☐ **Respiratory Therapy Student**

FOR OFFICE USE:

DATE COMPLETED:_______________ **COMPLETED BY:**__________________

Rev 03/2020

UNIVERSITY HEALTH SYSTEM
CONFIDENTIALITY AGREEMENT

I, the undersigned, hereby acknowledge receipt of a userid and password giving me access to the Hospital Information System of the University Health System, Bexar County, Texas (hereafter referred to as the University Health System) computer system. I understand and acknowledge that this userid and password combination is unique to me and is the electronic equivalent of my signature, with no difference in liability existing between my written and electronic signatures.

I further understand that this userid and password May give me access to confidential patient health care and financial information, employee personnel information, physician information, and business information relating to the University Health System (herein referred to as Information), and that the University Health System regards maintaining the confidentiality of this information to be of paramount importance.

Therefore, in consideration of the foregoing, I agree to the following:

1. **Information to be confidential**. All Information obtained by me, or on my behalf, whether by me, my office staff, agents, employees or any other person whatsoever, will be maintained in confidence by me, or by any other person acting on my behalf. I further agree that Information will be obtained and used only as necessary to perform my professional responsibilities.

2. **Scope of Information**. I agree that I will use the userid and password only to obtain access to that Information necessary for me to perform my Professional responsibilities.

3. **Use of Userid, Password and Signature Stamp**. I will not disclose my userid and password to any person or entity, nor will I attempt to learn or use any other person's userid and password. I will not share my Signature Stamp with any person.

4. **Issuance of New Userid and Password**. If I have any reason to believe that the confidentiality of my userid and password has been compromised, I will notify the Data Security Administrator immediately so that the suspect userid and password may be deleted and a new userid and password assigned to me.

5. **Responsibility for Self**. I recognize that I am responsible for all actions performed at a workstation activated with my userid and password; therefore, I will terminate the session before leaving the workstation.

6. **Responsibility for Others**. If applicable, I hereby specifically accept responsibility for ensuring that my office staff, agents, employees, or any other person acting on my behalf, in connection with Information, will abide by the terms and conditions of this Confidentiality Agreement.

7. **Violation of Conditions**. I recognize that violation of any of these conditions may result in withdrawal of computer access, termination of employment for employees, denial of hospital access for non-employees, and other disciplinary actions.

8. **Indemnification**. I agree to indemnify and hold the University Health System harmless from any and all liability, loss, or damage, including attorney's fees, that the University Health System may suffer as a result of claims, demands, costs, or judgements against it arising from the breach or violation of any provisions of this Agreement by me and/or my staff, agents, employees, or any other person acting on my behalf. I further agree to notify the University Health System in writing, within ten (10) days by registered U.S. Mail, of any claim made against me or my office staff, employees, and/or agents, on the obligations indemnified against herein.

I have also received, read, and understood the Information Asset/Use Policy 2.08.02

IN WITNESS WHEREOF, I have executed this agreement at San Antonio, Texas, this _________ day of __________, 20_____.

HOSPITAL INFORMATION SYSTEM USER

PRINT: ___________________________________

SIGNATURE: ______________________________

WITNESS

PRINT: ___________________________________

SIGNATURE: ______________________________

USER'S LEGAL SIGNATURE (AS IT APPEARS ON LICENSE): ______________________________________