SECURITY ACCESS REQUEST – MEDICAL STAFF

Please remit completed form to:
Medical Staff Services
1600 Wallace Blvd, Amarillo TX 79109
Fax: (806) 212-2233

ACCOUNT INFORMATION

Print Legal Name:
Main Office Phone Number:
Email Address:
Physician Number:
Account Expiration Date:
Specialty:

	New Account		Additional Application Access		Name Change		License Change
	Physician		Resident		Student (requires an expiration date)		
	Other: Physician Staff						

VERIFICATION QUESTION (Check box to the left)

	Pet's Name		Mother's Maiden Name		City of Birth		Spouse's Middle Name

Verification Question Response:

SYSTEM ACCESS REQUESTED (Check all that apply. Business justification required.)

X	General Network	X	Invision/GUI		OBIX Perinatal Data System (OB Physicians Only)
X	Net Access		PACs	X	VPN Remote Access

** DOES NOT NEED A BSA EMAIL ACCOUNT**

BSA MEDICAL STAFF SERVICES VERIFICATION (The Medical Staff Services Department is only verifying that the Supervising / Responsible Physician is a member of the Medical Staff at BSA.)

Print Name:	Signature:

SECURITY ACCESS REQUEST CONFIDENTIALITY AGREEMENT (Please read carefully)

Account Holder and Supervising/Responsible Physician:
I agree to all terms and conditions of the BSA Information Security Policies and the Security Access Confidentiality Agreement. Any breach of confidentiality or failure to comply with these guidelines is subject to disciplinary action, including possible suspension/termination of clinical privileges and/or loss of employment. I may also be subject to criminal penalties and civil or regulatory liability. I agree to indemnify BSA, and hold BSA harmless from any and all damage, loss, liability or expense, including attorney fees and costs, which arise out of or result from my breach of this Confidentiality Agreement.

I acknowledge receipt and understanding of this agreement and the BSA Security Access Confidentiality Agreement, and agree to comply with BSA Information Security policies. I agree to follow this agreement and to preserve the confidentiality of patient information and patients being served by Baptist St. Anthony's.

Supervising/Responsible Physician:
I agree to notify BSA when the requested account is no longer necessary and/or the account owner is no longer affiliated with me or my practice.

ACCOUNT OWNER'S SIGNATURE

Sign:	Date:
Print Name:	

SUPERVISING/ RESPONSIBLE PHYSICIAN **MANDATORY** (Physician requesting and approving access for affiliated party)

Print Name:	Signature:

SECURITY ACCESS CONFIDENTIALITY AGREEMENT

Please remit completed form to:
IS Operations
1600 Wallace Blvd, Amarillo TX 79109
Fax: (806) 212-2921

CONFIDENTIALITY AGREEMENT (Please read carefully)

To be granted access to BSA Information Systems, you must read and agree to all of the following guidelines:

1. BSA policy states that it is the responsibility of the end user to maintain complete confidentiality of patient information. Disregard for this responsibility may result in disciplinary action, including loss of access privileges, and possibly termination of employment.
2. I will be issued a username and will be required to set a password, which will be necessary for me to perform my duties.
3. I will not share my username or password with another person and will fully comply with BSA's Password Management policy.
4. I understand that I must secure my password in such a fashion that it is not accessible to anyone else.
5. I will only attempt to access information for which I have a business need to know.
6. As a health care provider, I agree to protect any patient information downloaded from BSA's information systems by using appropriate security features on my electronic device.
7. I will not leave any electronic device unattended when logged on to BSA information systems.
8. I will sign off and exit fully from BSA's information systems when finished accessing protected information.
9. I will not access BSA's information systems under another user's credentials.
10. I will advise the Information Systems Department Help Desk at (806) 212-5599 immediately if my password, electronic device or any other hardware or documentation associated with access to BSA's information systems is lost, stolen, or is otherwise compromised.
11. As a healthcare provider or employee of a medical staff member, I will access only the health information of my patients and patients subject to a cross coverage/consultation agreement.
12. If I am a medical staff member, I will not request access to patient information for any office staff for any reason other than the delivery of healthcare treatment, payment or operations.
13. If I am a medical staff member, I agree that I am responsible for the actions of my employees and that violation of the Information Security Policies or this agreement can result in termination of my privileges.
14. I will report any violation of the BSA Information Security Policies to BSA's Information Security Officer (806) 212.5625.

I agree to all terms and conditions of this agreement. Any breach of confidentiality or failure to comply with these guidelines is subject to disciplinary action, including possible suspension/termination of clinical privileges and/or loss of employment. I may also be subject to criminal penalties and civil or regulatory liability. I agree to indemnify BSA, and hold BSA harmless from any and all damage, loss, liability or expense, including attorney fees and costs, which arise out of or result from my breach of this Confidentiality Agreement.

I acknowledge receipt and understanding of this agreement and agree to comply with BSA Information Security policies. I agree to follow this agreement and to preserve the confidentiality of patient information and patients being served by Baptist St. Anthony's.

ACCOUNT OWNER'S SIGNATURE

Signature:

Print Name: