North Alabama MEDICAL CENTER

North Alabama Medical Center and Shoals Hospital
Information Systems Access Form For Contract Employees and External Users
Please print all information except signatures.

Shoals HOSPITAL

Please check and complete one of the following areas:

Company/Vendor/Practice Name: IM Residency E-mail Address: _____

Address: NAME Phone Number: 1950

_____ Fax Number: _____

Reason for Request:

☒ New User ☐ Delete User ☐ User Access Change ☐ User Name Change ☐ Returning User - Previous Meditech Logon: _____

Need Access to: (Check all that apply) ☒ North Alabama Medical Center (ECM) ☐ Shoals Hospital ☐ Scribe (Need HIM Appr.)

☐ E-mail ☒ Meditech ☐ Lawson ☒ Network ☒ PACS ☐ PICIS ☐ VPN/RDS Other: _____

View Only access

I agree to utilize the Information Systems network, Meditech, and/or other applications in accordance with my professional responsibilities. I will access/view information only when I have a legitimate, job related "need to know," regardless of the extent of access provided. In addition, I agree to the following provisions:

- To maintain my password in the strictest confidence and not to disclose this password to anyone, at any time, for any reason.
- To contact Information Systems and request a new password if mine is accidentally revealed.
- Not to record passwords in any manner, as this increases the possibility of accidental disclosure.
- Not to disclose any portion of a patient's record without proper authorization.
- To sign off all computer systems when my work is completed.
- Not to access my record, a family member's record, or any other patient record for which I do not have a legitimate business reason, without a completed authorization on file in Medical Records at the appropriate facility.
- Keep all PHI in a HIPAA compliant manner.
- Accounts not utilized for 90 consecutive days will automatically be removed.

I further understand that the Facility Security Committee will review access of information in the Meditech system and that I may receive a letter of inquiry from this committee for any possible breaches of appropriate access. If a violation has occurred, disciplinary action will include discontinuance of user privileges and the evaluation of any additional sanction or action warranted by the situation.

User's Legal Name: _____ User's Signature: _____ Date: _____

Job Title/Credentials (MD,RN,CNA,ect.): MD Purpose for access request: observership

Is this access required for a limited time only? Yes If yes, what date does the access need to be removed? _____

Supervisor/Physician: Micaela Bales Supervisor/Physician Email Address: Mabales@namccare.com

Supervisor/Physician Signature: MBB Phone: 1950 Date: _____

Hospital Use Only: Approving HIM/Medical Staff Services Director's Name: _____ Signature: _____ Date: _____

Information Systems Department Use Only Method of Entry: ☐ On-site ☐ RDS Meditech Access Template Used: _____

Work Order Number: _____ Date Completed: _____ Completed By: _____

Fax completed form to 256-768-8243 or e-mail to IS9411@namccares.com - access will be granted within 5 business days after approval by appropriate department director/manager. Incomplete forms will not be processed.

Updated 03-19-2020