MONTEFIORE

Request To Access Montefiore's Clinical Information Systems

SECTION A

TO BE COMPLETED BY APPLICANT

*IMPORTANT NOTE:
CIS FORM WILL NOT BE PROCESSED
WITHOUT A CHANGE REQUEST #

APPLICANT INFORMATION

***CHANGE REQUEST #** |__|__|__|__|__|__|

Last Name: _____

First Name: _____

Middle Initial: _____ Sex: _____

Social Security: #_____-_____-_____

Date of Birth: _____

Employed by MMC? ☐ Yes ☐ No

☐ Moses ☐ Weiler ☐ North

☐ Other MMC Location (Specify): _____

Department: _____

Job Title: _____

Office Phone: _____

Beeper: _____

☐ **New Associate** ☐ **Existing Associate**

If NOT Employed by MMC, Provide Name of Employer:

_____

Reason for Access: _____

SECTION B

TO BE COMPLETED BY DEPARTMENT HEAD OR SUPERVISOR. ONCE COMPLETED PLEASE FAX TO SECURITY ADMINISTRATOR AT: (914) 457-6315

SECURITY AUTHORIZATION

REQUEST TO ACCESS (Check all that apply): ☐ CIS ☐ EPF ☐ PACS ☐ ED WELLSOFT ☐ Tele-Tracking ☐ C-EMR

Will This Access Be Used For Registration? ☐ Yes ☐ No

CIS: Existing User To Mirror Access For: _____

EPF: Provide Access to Mirror Record View Group: ☐ Clinician ☐ Other: _____

☐ Assign New ID (New User) ☐ Assign New Security Class (Transfer/Promotion)

☐ Deactivate ID ☐ Reactivate ID ☐ Change User Registration Information

☐ Indicate Any Other Changes:_____

PRINT AND SIGN YOUR NAME

_____(____)_____/___/__

AUTHORIZING DEPT. HEAD / SUPERVISOR SIGNATURE **Phone Number** **TITLE** **DATE**

FOR EPF ACCESS:

PRINT AND SIGN YOUR NAME

_____(____)_____/___/__

AUTHORIZING SIGNATURE TO ACCESS EPF (HIM DIRECTOR OR DESIGNEE) **TITLE** **DATE**

SECTION C

FOR SECURITY ADMINISTRATION USE ONLY

MIS SECURITY ADMINISTRATION

☐ CONFIDENTIALITY AGREEMENT SIGNED ☐ ADDITIONAL AUTHORIZATIONS ASSIGNED

USER NUMBER ASSIGNED |__|__|__|__|__|__|__|__|__|__| CLASS ASSIGNED: _____

_____

SECURITY ADMINISTRATOR **DATE**

MONTEFIORE

MONTEFIORE MEDICAL CENTER
The University Hospital for the
Albert Einstein College of Medicine

PATIENT INFORMATION CONFIDENTIALITY AGREEMENT
FOR ALL EMPLOYEES AND MEDICAL STAFF

Name: _____ Position_____
PRINT CLEARLY

Confidentiality Agreement

I recognize that, in the course of performing services at Montefiore Medical Center, I may gain access to Montefiore patient information, which is protected by Montefiore Administrative Policy and Procedures, federal, state, and city regulations. I agree that:

- I will keep confidential all patient information to which I gain access whether in the direct provision of care or otherwise.
- I will access and use patient information only on a "need to know" basis as necessary for the provision of patient services and /or hospital operations.
- I will disclose patient information only to the extent authorized and necessary to provide patient care.
- I will not discuss patient information in public places or outside of work.

I understand that it is my obligation and responsibility to ensure the confidentiality of all patient information. Improper disclosure or misuse of patient information, whether intentional or due to neglect on my part, is a breach of Montefiore policy, which will result in disciplinary action and could result in dismissal.

Signature:_____ Date:_____/_____/_____

Computer Access Agreement:

During the course of my work at Montefiore Medical Center, I may be assigned a unique user id and instructed to develop a personal password so that I may access Montefiore's Clinical Information Systems. I understand that in order to receive a unique user id and a password, I will be required to complete training in the use of and responsibilities for the usage of the respective Montefiore Information Systems. I understand that my access identifiers are the equivalent of my legal signature and I will take all reasonable and necessary precautions to protect them. In order to maintain confidentiality of patient information stored in Montefiore Medical Center's Information Systems, I agree that:

- I will keep my unique user id number and passwords confidential and will not share them with anyone for any reason.
- I will not leave an in-hospital or remote computer terminal unattended without first logging off.
- I will take all reasonable and necessary precautions to secure both in-hospital and remote terminals from unauthorized access.
- I will contact security administration (718-920-4554) immediately if I have reason to believe that my unique user id number or password has been revealed for any system.
- I will report immediately to security administration (718-920-4554) any suspected unauthorized access to patient information.
- I will inform Montefiore's security administration (718-920-4554) if I leave my current employment so that my access to Montefiore's Clinical Information Systems will be deactivated.

I understand that Montefiore Medical Center will use my identification number and/or password to monitor the CIS system by means of patient- and user-specific audit trails and that my use of the system may be audited at any time. I understand that it is my obligation and responsibility to protect my unique user id number and password from improper use, and that not to do so is a breach of Montefiore policy, which will result in disciplinary action including possible loss of access to the CIS system and /or dismissal.

Signature:_____ Date:_____/_____/_____