



DESCRIPTION OF SYSTEM

GE FlowCast (IDX) is an integrated practice and hospital management system that offers access management, patient financials, and robust business intelligence and reporting capabilities.

THIS INFORMATION IS TO BE FURNISHED BY THE APPLICANT (PLEASE PRINT LEGIBLY)

- Please complete ALL sections on ALL pages of this form (Incomplete forms will not be processed).
- The applicant must sign the yellow section (**SECTION A**) of page 2. The supervisor must sign the green section (**SECTION B**) of page 2.

NEW USER ACCESS (Specify Start Date: _____)

MODIFY USER ACCESS

APPLICANT'S INFORMATION

FIRST NAME	M.I.	LAST NAME	PHONE NUMBER (WITH AREA CODE)
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REQUIRED *FIELDS*	C# *REQUIRED* (IF NO C#, MUST INCLUDE DATE OF BIRTH)	DATE OF BIRTH (IF NO C# IS PROVIDED, MUST INCLUDE DATE OF BIRTH)
	MEDICAL USER NAME (EMAIL) *REQUIRED*	

POSITION TITLE	ORGANIZATION NAME (e.g., ABLEH, UMH, UMHC, UMMG, OTHER)
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LOCATION BUILDING	DEPARTMENT	DIVISION
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FRONT END - PLEASE CHECK COURSE THAT APPLIES

- | | |
|--|---|
| <input type="checkbox"/> SYSTEM CONCEPTS & PATIENT INQUIRY
<input type="checkbox"/> REGISTRATION & INSURANCE
<input type="checkbox"/> EWS (APPT SCHEDULING)
<input type="checkbox"/> VM/SCHED (HOSPITAL SCHEDULING XX, XS, XE)
<input type="checkbox"/> MASTER SCHEDULES
<input type="checkbox"/> OPEN REFERRALS
<input type="checkbox"/> FRONT DESK | <input type="checkbox"/> IMX SCANNING & INDEXING
<input type="checkbox"/> CHART TRACKING FOR HIM
<input type="checkbox"/> OTHER (e.g. Pt Locator, In-transit Receipts, Census, HMO Enrollment, Pt flag, Insurance verifier, Admitting) please specify below:
_____ |
|--|---|

BACK END - PLEASE CHECK COURSE THAT APPLIES

- | | |
|---|---|
| <input type="checkbox"/> BAR CHARGE ENTRY (Posting charges to the system via TES)
<input type="checkbox"/> CHARGE CORRECTIONS
<input type="checkbox"/> BAR PAYMENT POSTING (F4)
<input type="checkbox"/> PAY CODES _____ | <input type="checkbox"/> PCS COLLECTIONS
<input type="checkbox"/> PCS ACTION CODES _____
<input type="checkbox"/> SUP (Supervisor/Manager only) |
|---|---|

System access will be granted to those individuals for the areas where competencies have been met. For more information, please contact CET Training at 305-243-3665.



GE FlowCast (IDX) CC
Electronic Health Record (EHR) Access Request Form
University of Miami Miller School of Medicine



HIPAA (Privacy & Security of Protected Health Information)

The University of Miami has developed policies and procedures for the use and disclosure of University patient health information in compliance with applicable state and federal laws, including the **Privacy & Security** standards promulgated under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. By signing this form you hereby agree to comply with HIPAA. Furthermore, by signing this form, you affirm the fact that you've taken and successfully passed the 'HIPAA Privacy & Security Awareness' online training. If you have any questions concerning our policies and procedures, please contact the Office of Privacy and Security at **305-243-5000**, email us at hipaaprivacy@med.miami.edu, or visit our site: <http://med.miami.edu/hipaa>.

SECURITY ADMINISTRATION PROCEDURES

1. Complete the Access Request form and fax it to: Clinical Enterprise Technologies at 305-243-7355.
2. Access will be granted upon successful completion of the course and upon receipt of this completed Access Request Form.

If you need assistance, please contact the CET Support Desk at 305-243-7339.

APPLICANT'S SIGNATURE

SECTION A	By signing this access request form, I understand and agree to maintain the confidentiality of patient health information and will refer all requests for disclosures to the Health Care Provider Medical Records Custodian or the hospitals' HIM departments. Furthermore, I understand that I will receive a unique username and password that is not to be shared and/or made public and will sign off the system before leaving the workstation. In addition, I understand that if I don't access the system for over 3 months, my account will be deactivated.		
	APPLICANT'S SIGNATURE	APPLICANT'S PRINTED NAME	DATE

APPLICANT'S UM SUPERVISOR, AUTHORIZING MANAGER, SPONSOR/LIASON OR ADMINISTRATOR

SECTION B	By signing this access request form, I acknowledge and confirm that the above applicant needs access to the system referred to in this application in order to perform his/her job functions. I will notify the CET department upon this employee's termination and/or transfer to a different position or department where access must be assessed as it relates to their job functions by their new supervisor.		
	SUPERVISOR'S SIGNATURE	SUPERVISOR'S PRINTED NAME	SUPERVISOR'S PHONE # DATE