MILLER SCHOOL OF MEDICINE UNIVERSITY OF MIAMI

IntelliDose Provider

Electronic Health Record (EHR) Access Request Form
University of Miami Miller School of Medicine

IntelliDose®

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

Please complete ALL sections on ALL pages of this form (Incomplete forms will not be processed)

☐ **NEW USER ACCESS** ☐ **MODIFY USER ACCESS**

IF FELLOW, CHECK MARK THE BOX BELOW

☐ **Fellow**

Additional UM-JMH Confidentiality Agreement signature required (refer to attached form on page 3)

REQUESTOR'S INFORMATION

LAST NAME	M.I.	FIRST NAME	MEDICAL USER NAME (EMAIL) *REQUIRED*

POSITION TITLE (e.g. Assistanct Professor/MD)	EMPLOYEE ID#	TELEPHONE/BEEPER

ORGANIZATION NAME	LOCATION (BLDG/RM) (e.g. Bldg-SCCC/Rm#3023)	DEPARTMENT/DIVISION (e.g. Medicine/Cardiology)

ROLE/FUNCTIONAL ACCESS REQUIRED

☐ **UM Physicians that require access to be final signers for chemotherapy treatment plans.**

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Dept. of Physician Services Representative (UMHC Rm. 4037, 305-243-4395)

***All licensed practitioners require signature from the Department of Physician Services indicating they are privileged & licensed if applicable.**

☐ **Fellow, ARNP, PAs that prepare chemotherapy & non-chemotherapy orders for final signature by UM Physicians.**
This access has been approved by UM Supervising Physician and is in accordance of UM policies and procedures.

UM Supervising Physician Signature	_UM Supervising Physician Printed Name_	_UM Supervising Physician UPIN/NPI_

Access approval for chemotherapy order entry ______________________________
Dept. Of Physician Services Representative (UMHC Rm. 4037, 305-243-4395)

***All ARNPs & PAs must submit proof of ONS chemo class.**
***All licensed practitioners require signature from the Department of Physician Services indicating they are privileged & licensed if applicable.**

By signing this access request form 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. I will be using IntelliDose within 3 weeks of the date of my training.

It is the responsibility of the user requesting access and the UM supervising physician, if applicable, to notify UMCET immediately upon any changes in credentials and/or privileges status.

Requestor Signature: ______________________ UPIN/NPI #:______________________ Date: ______________________

IMPORTANT: REFER TO THE STEPS IN THE SECOND PAGE TO PROPERLY SUBMIT THIS FORM.

DESCRIPTION OF APPLICATION

IntelliDose is an electronic system that automates chemotherapy order-writing and chemotherapy nursing documentation.

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. 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 required information on the EHR Access Request form.**
2. **All licensed practitioners require signature from the Department of Physician Services indicating they are privileged & licensed if applicable.**
3. **All fellows must review and sign the UM-JMH confidentiality agreement.**
4. **Return the completed form(s) to the Clinical Information Management Systems Department. The form can be faxed to 305-243-7355. Training Registration is not complete until the form(s) are received with appropriate signature(s).**
5. **Username and password will be assigned & sent via email once the request is approved and the training has been completed.**

Need HELP? Contact the CIMS Support Desk at 305-243-7339.

Requestor Signature: ______________________________ **Date:** ____________________

IMPORTANT: SIGN ABOVE TO CONFIRM THAT YOU'VE REVIEWED AND UNDERSTOOD THE CONTENTS OF THIS PAGE.

UMCET STAFF ONLY

Date form received:	Access processed by:	Date request completed:
Username assigned:	Access group assigned:	
Date of training:	Trained by:	ARF Status/Comments (i.e. pending info, missing info, etc.):

CONFIDENTIALITY AGREEMENT FOR ACCESS TO UNIVERSITY OF MIAMI SYSTEMS BY PUBLIC HEALTH TRUST PERSONNEL

In the course of my employment/assignment at the Public Health Trust, I may come into contact with or have possession of certain confidential or proprietary information of The University of Miami. This information may include but is not limited to: (i) student information or records; (ii) patient information or record; (iii)employee information or records; (iv) business data, record or information, (v) the confidential or proprietary information of third parties which the University is contractually obligated to maintain as confidential or; (vi) other data, trade secrets, documents, records, processes, operations and issues, or information considered by The University of Miami to be confidential; (hereinafter all information discussed above is collectively referred to as "Confidential Information").

As a condition of my access to University of Miami systems, I hereby agree that I will not at any time during or after my employment/assignment with the Public Health Trust, access or attempt to access Confidential Information or disclose or discuss any Confidential Information with any person whatsoever or permit any person whatsoever to examine or make copies of any Confidential Information prepared by me, coming into my possession, or under my control, or use such Confidential Information, or facts of occurrences, other than as necessary in the course of my employment/assignment. When Confidential Information must be discussed with other employees in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who do not or should not otherwise have access to the Confidential Information.

The importance of using my own code to sign-on to any University system for security reasons has been explained to me. I understand that all transactions performed by me will have3 my user ID associated with the transaction. I also agree that I will not give my password to any on and I must promptly request to have my password changed if I believe it is being misused. I also understand and agree that my continued access to the University of Miami systems and Confidential Information depends on my abiding by the terms of the University's Information Technology policies; including but not limited to Computer Access and Confidentiality, Use of University Computing Facilities, World Wide Web, and Use of Electronic Communications (policies A045,A047, and A055), which are available to me under the Information Technology Policies section website (http://www.miami.edu/ComSec/Infotech/Infosec.htm) of the University of Miami.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) has established privacy and security standards that I must adhere to as I carry out my daily responsibilities requiring access to University of Miami patient information. In accordance with the level of access of my job description, I must respect and keep patient information confidential whether in oral, written or electronic format. Furthermore, I agree to follow the University of Miami HIPAA policies and procedures, which are available to me on the University of Miami website www.med.miami.edu/hipaa and for which I have received training, as applicable to my job function.

I understand that violation of this agreement may result in denial of my access to the University of Miami's systems and/or disciplinary action and/or legal action.

____________________________ ________________________
PHT Employee's Signature Date

____________________________ ________________________
Name Printed Department