Catholic Health Initiatives

Community User Access Request
Health Informatics Department
External Access Management Unit

Complete this form for users who are not employed by Franciscan that will access Franciscan Electronic Health Records. Users may access systems via a web site link from outside Franciscan Health System facilities.

___ **Initial Access Request** - Signed and Witnessed Confidentiality Agreement are also required with initial request.
___ **Addendum to Initial Access Request** (additional access or changes in system access)

USER NAME / INFORMATION (Required INFORMATION BELOW, if not applicable please mark N/A)

Name / Professional Degree (First, Middle, Last, Degree)_____

Specialty / Job Title: _____

Check all that apply:
___ Medical Provider (MD, PA, ARNP, Etc.) – Complete highlighted section immediately below
___ Office Staff (Office staff of Medical Provider)
___ Other User – Detailed reason for access requirements_____

Medical Providers only: NPI # _____ WA State License # _____

Office Name _____ Office Manager Name _____

Office Address _____ City_____ State _____ Zip _____

Office Phone_____ Office Fax _____

User Email_____

EXTERNAL SOFTWARE ACCESS (Check system access below)

Does your equipment currently meet the required specifications for each system?

____**Yes - Meets or exceeds the standard** ____**Upgrades Completed** ____**Unknown**

___**FHS EpicCare Link** (Referring Providers, Clinical Staff, Nurses, Business and Administrative staff)

If you are requesting this type of access, please see page 2. Additional information is required.

Logins will be issued to each individual user and may not be shared. **Passwords** are issued to each user and must be changed at least every 180 days. System access can and will be audited. The user whose login is identified during an audit will be held accountable for access violations. Per policy, the Individual authorizing access will be held accountable for the user's actions.

I understand my responsibilities as outlined in the "Access to Electronic Health Records" policy. I have also signed a "User and Confidentiality Agreement for Access to Franciscan Health System Electronic Health Records" and understand my responsibilities as outlined In the agreement.

User Signature: _____Date:_____

Authorizing Provider: (Please print name)_____

Authorizing Provider Signature: _____

Internal Use Only: _____

Catholic Health Initiatives

Community User Access Request
Health Informatics Department
External Access Management Unit

If you have any questions, please contact the Access Administrator:

EpicCare Link : 253-792-2283
Email: tacomaeclink@chifranciscan.org

For EpicCare Link Access requests:

Authorizing Provider _____

Site Administrator is: Existing_____ New_____

Site Administrator Name: _____

Phone: _____

Email: _____

User is: Clinical User____ Non- Clinical User ____ Biller/Coder ____ Site Administrator _____

Do providers at this clinic have FHS Epic access: Yes ____ No ____
If No, please list all providers associated with this clinic. (This will allow access to your providers' patient lists)

First Name	Last Name	Credentials	NPI