MultiCare
BetterConnected
Information Services

Information Services
User Registration
Applications/Systems

Personnel Information Section (please type or print all applicable fields)

Select one of the following:

☐ MHS Employee ☐ CareConnect (ASP) ☐ Student ☐ Medical Student
☐ Community Provider ☐ Agency ☐ Resident ☐ Vendor ☐ Other _____

Legal Last Name	**Legal First Name**	**MI**
Employee ID # or (Month/Day [MM/DD] of Date of Birth for non-Employee**)**	**Float ?** ☐ Yes ☐ No	
Job Title/Role	**Location**	
Department/Unit/Clinic	☐ Allenmore ☐ Good Samaritan ☐ Mary Bridge ☐ Tacoma General ☐ Covington	
Phone/Ext.	☐ MMA Clinic _____	
Email		
Manager	☐ Other_____	
Start Date for Access	**End Date (if applicable)**	

For Non-MHS Employee (For Agency Employees, Travelers, Students, or Vendors)

MHS Sponsor Name	**MHS Sponsor E-Mail**	**MHS Sponsor Phone**
Agency/School/Company name	**Agency/School/Company Phone/Ext.**	

Read and sign the following statement: My signature indicates my understanding that all information contained within MultiCare's Information Systems is considered confidential and should only be shared with others for business related purposes relative to my job. I accept responsibility for taking appropriate measures to secure my workstation. I also agree to keep my password private and to not share it with others.

Employee/User signature	**Date**

Management/Educator Information Section (to be filled out by manager/educator)

Required Application Access	**Login ID** (if existing user) _____	**Special set-up instructions?**
☐ MultiCare Connect (Epic/Hyperspace)	☐ Pyxis Medstation	
☐ Windows Log-On (MHS domain account)	☐ Lawson	
☐ MultiCare.Org E-mail Account	☐ Other:_____	
☐ MultiCare Imaging PACs	☐ Other:_____	
Remote access		
☐ Nortel Contivity VPN Client software (includes RSA Token)		
☐ MyPortal (Citrix) website		
Citrix Applications Needed		
☐ _____		
☐ _____		

IMPORTANT: Please explain your business needs for the above selected access types.

MHS Confidentiality & Use Statement

I understand that MultiCare Health System ("MHS") Information Services ("IS") provides a wide range of services and support to physicians and other healthcare providers, and their support staffs, within its service area, including the provision of practice management tools and access to electronic medical records and patient accounting systems.

I acknowledge that MHS maintains patient records and information in a confidential manner. Information in patient records or information collected from the patient is kept in strict confidence in accordance with the Uniform Health Care Information Act, the Health Insurance Portability & Accountability Act, and other state and federal laws. Systems for the privacy and security of patient records have been developed and are an important part of protecting patient confidentiality.

I have requested user identification and a password allowing me to access confidential patient records maintained by MHS within one or more Application(s) or System(s), for the purpose of providing medical care and treatment to my patients., If granted privileges to access such information, I agree to abide by all MHS policies and procedures pertaining to access and use of MHS Application / System records. I understand such policies and procedures may change from time to time, and I agree to participate in appropriate Application / System user education and training on an ongoing basis, and to familiarize myself with all applicable MHS policies and procedures.

I have reviewed the MHS policies and procedures regarding patient confidentiality. As a condition of my access to and use of information maintained within MHS Application(s) / System(s), I agree to abide by all established MHS policies relating to patient confidentiality. I will not access patient records or information via hard copy or information system unless I have a "need to know" in order to provide medical care and treatment to my patients.

I understand that entries in patient records within MHS Application(s) / System(s) are accessible by other health care providers, and once entered become part of the patient's composite health record within MHS and cannot be removed or segregated from other records within MHS applicable to such individual patients, particularly with regard to any MHS Patient Care Information System(s).

I understand that unauthorized use or disclosure of patient information may subject me to civil liability under state and/or federal law, and that improper disclosure may also constitute a crime. I understand and authorize MHS to monitor and audit my use and access of all MHS Application(s) / System(s).

I agree to use and access protected health information strictly for lawful purposes within the scope of my duties and responsibilities and for no other purpose. I accept responsibility for taking appropriate measures to secure my workstation. I also agree to keep my MHS Network System password(s) private and not share password(s) with others.

I assure MHS that I will not, under any circumstances, use or disclose patient information for any unauthorized purpose, and I will take appropriate steps to protect the confidentiality of patient information and records.

I will immediately report to the MHS Information Services Help Desk any observed or known violations of this user agreement by myself or others having access to MHS Applications or Systems.

I understand that unauthorized use or disclosure of patient information constitutes a violation of my employment or my clinic's or department's agreement with MHS allowing access to MHS Application(s) or System(s), and that willful violation of MHS rules may result in termination of my access or my clinic's or department's rights to utilize MHS Application(s) or System(s).

I have read and understand the above statements.

_____
Name (please print)

_____
Signature

_____
Witness Name (Please Print)

_____
Date

_____
Witness Signature