LGH
LOWELL GENERAL HOSPITAL

Remote Practice Request for Additional Staff Access and Termination Notification

PRACTICE INFORMATION:

Practice Name: _____

Primary Address: _____ **Phone:** _____ _____ - _____

_____ **Fax:** _____ _____ - _____

Address: _____ **Phone:** _____ _____ - _____

_____ **Fax:** _____ _____ - _____

Specialty: _____ **Group Name Affiliation:** _____

Primary Contact: _____ **Position:** _____ **Email:** _____

PERSONNEL:

Provider Name:	**NPI #:**	**State License #:**	**Taxonomy Code:**
_____	_____	_____	_____

☐ **Access Requirements** **(please check)**

☐ **LGH EMR** ☐ **Pyramis** (EKG & Stress) ☐ **Horizon Rad Station** (Radiology Images)

☐ **Termination** **(please specify what employee had access to)** **Date of Termination:** ____ / ____ / ____

☐ **LGH EMR** ☐ **Pyramis** (EKG & Stress) ☐ **Horizon Rad Station** (Radiology Images)

Employee Name	**Role**	☐ **Access Requirements** **(please check)** ☐ **Termination** **(please specify what employee had access to)** **Date of Termination:** ____ / ____ / ____
_____	_____	☐ **LGH EMR** ☐ **Other** _____

Employee Name	**Role**	☐ **Access Requirements** **(please check)** ☐ **Termination** **(please specify what employee had access to)** **Date of Termination:** ____ / ____ / ____
_____	_____	☐ **LGH EMR** ☐ **Other** _____

Employee Name	Role	☐ Access Requirements (please check) ☐ Termination (please specify what employee had access to) Date of Termination: ____ / ____ / ____
_____	_____	☐ LGH EMR ☐ Other _____

Employee Name	Role	☐ Access Requirements (please check) ☐ Termination (please specify what employee had access to) Date of Termination: ____ / ____ / ____
_____	_____	☐ LGH EMR ☐ Other _____

☐ **Name Change**

Current Name	New Name	Date of Change:
_____	_____	_____

Physician or Office Manager's Signature: _____ **Date:** _____

Print Name: _____

INSTRUCTIONS:

Please complete this form to request access for a new/existing employee or for an employee who has terminated employment with your practice.

Mail or fax this form, along with a signed *Confidentiality Agreement* for each employee to:

Information Services Department
Lowell General Hospital
295 Varnum Avenue
Lowell, MA 01854-2193
Fax: 978-788-7810

LOWELL GENERAL HOSPITAL

DEPARTMENT OF INFORMATION SYSTEMS
CONFIDENTIALITY AGREEMENT

I understand that Lowell General Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Lowell General Hospital must assure the confidentiality of its human resources, clinical, payroll, fiscal, computer systems, and management information (collectively, "Confidential Information").

In the course of my employment/assignment/affiliation at Lowell General Hospital, I understand that I may come into the possession of Confidential Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of Lowell General Hospital's Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. In addition, I understand that my personal access code, user ID(s), and password(s) used to access computer systems are also an integral aspect of this Confidential Information.

2. I will not access or view any Confidential Information, or utilize equipment, other than what is required to do my job.

3. I will not access my own patient account/medical record/employee file. I understand I have a right as a patient/employee to view this information, but must do so through the proper channels via the medical records department or my physician for the medical record, patient accounting for billing information, and human resources for HR/Payroll information.

4. I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, elevators, in the cafeteria, on public transportation, in restaurants, and at social events). It is not acceptable to discuss Confidential Information in public areas even if a patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.

5. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.

6. I will not willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.

7. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information in Lowell General Hospital's computer system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Confidential Information from Lowell General Hospital's computer system to unauthorized locations (for instance, home).

8. I will respect patient confidentiality when accessing information from a remote location, such as an office or home.

9. I will log off any computer or terminal prior to leaving it unattended.

10. I will comply with any security or privacy policy promulgated by Lowell General Hospital to protect the security and privacy of Confidential Information.

11. I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of this Agreement or any of Lowell General Hospital's information security or privacy policy. The transgression will in turn be reported to the Chief Information Officer for review.

12. Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information to Lowell General Hospital.

13. I agree that my obligations under this Agreement will continue after the termination of my employment.

14. I understand the violation of this Agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges, in accordance with the Lowell General Hospital's Confidentiality of Computerized Information Policy, as well as legal liability.

15. I further understand that all computer access activity is subject to audit.

By signing this document I understand and agree to the following: I have read the above agreement and agree to comply with all its terms.

Signature of employee/physician/student/volunteer_____

Print Name _____ Date _____