User Access Request

Phone: (574) 968-1018 Fax: (574) 968-1020

☐ **New User** **Training Date:**	☐ **Modify User** **Effective Date:**	☐ **Terminate User** **Effective Date:**
☐ **PowerChart View Only**	☐ **PowerChart EHR**	☐ **MHIN Direct Messaging**
☐ **PowerChart VO & Register**	☐ **PowerChart EHR MU**	☐ **MHIN Direct Messaging Delegate**
	☐ **PowerChart EHR Scanning**	
	☐ **PowerChart EHR Direct Address**	

User Information

(Completed by Client Security Officer or Designee/Manager, faxed to MHIN: 574-968-1020 or emailed to UET@mhin.com)
Upon receipt of the completed form, MHIN will contact your office within 3 business days to release account, verify training dates and/or schedule training as needed. ***Please call MHIN if the user account needs to be activated in a more immediate time frame.***

Last Name: _____ **First Name:** _____ **MI**: _____

Organization Name: _____ **Department:** _____

Job Title: _____ **Provider NPI:** _____

Work Phone: _____ **E-mail:** _____

Manager Name: _____ **Manager Signature:** _____
(Please print)

Security Officer or Designee Name: _____ **Security Officer or Designee Signature:** _____
(Please print)

User Security Agreement

(Completed by User)

I understand that security, confidentiality, privacy, and safeguarding of protected heath information (PHI) are of critical importance for Michiana Health Information Network (MHIN) and my organization. It is my duty to keep information obtained through access to MHIN applications confidential. I agree that I am bound by the terms and conditions of this agreement.

- I agree to comply with the rules and regulations of the "HIPAA Security and Privacy Rule", and any subsequent regulations pertaining to the privacy and security of health information.
- I will not disclose PHI at any time, for any reason, other than for patient care, as defined by the HIPAA Security and Privacy Rule.
- I will not disclose my password to anyone for any reason.
- I will use only my assigned username and password to access MHIN applications.
- I will access the minimum necessary PHI in MHIN applications only when it is essential to conduct business as a member of my healthcare team.
- I will only access PHI for patients with whom my healthcare team has an established relationship, intend to establish a relationship, or for emergent care purposes.
- I am aware that for audit purposes my name is attached to actions performed in MHIN applications; including, but not limited to opening a patient chart and sending, receiving and viewing messages.
- I understand that patients may receive information about users who have accessed their records in any MHIN application.
- I understand that I am responsible for all MHIN application accesses under my user account. If I leave my computer for any reason, I will suspend or log out of any open MHIN application to prevent other persons from accessing MHIN applications under my user account.
- I understand that my user account will be inactivated as soon as I terminate employment from my current healthcare team, or if I transfer to a position where access to MHIN applications is not required to perform my job duties.
- I understand that I have the ability to provide and revoke delegate or proxy access solely to other MHIN application users. I will delegate access to others within my organization only when necessary to conduct business as a member of my healthcare team.
- I will notify the MHIN Helpdesk immediately if I have reason to believe that my user account has been compromised in any manner, including a compromise of password confidentiality. I understand that my password may be reset in the event of a security compromise.
- I understand that if I need my password reset, I need to call the MHIN Helpdesk. To verify my identity, the Helpdesk associate will ask me to provide personal information as listed below.
- I agree that the terms of this agreement apply when I am delegated or proxied to access another MHIN application user's inbox.

Last four digits of Social Security #_____ **< OR >** Employee Identification #: _____

I have read and understand the above information. I agree to the above terms as an individual user of MHIN application(s).

Printed Name: _____ **Employer:** _____

User Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

MHIN Authorization/Documentation

(MHIN Use Only)

MHIN Security Officer: _____ **Date:** _____

User Account Activated By: **Date:**