

Physician Link Account Setup

Check one:

- New** Token
 Replacement Token
 Modify Account Setup

Please complete form with all signatures affixed and fax to (415) 600-7072

NOTE: YOU MUST COMPLETELY FILL OUT THIS FORM. INFORMATION IN THE BOX BELOW IS MANDATORY ESPECIALLY A VALID EMAIL ADDRESS AS ALL CORRESPONDENCE IS DONE VIA EMAIL. PLEASE PRINT LEGIBLY.

Name: _____			
Last	First	MI.	
Address:		Please answer the following for identification purposes: Last 4 Digits of Social Security Number:	
City:	State:	Zip Code:	Last 4 Digits of Home Phone:
Email Address:		Work Phone:	
Medical Records Campus - for Pickup of Token			
<input type="checkbox"/> California <input type="checkbox"/> Davies <input type="checkbox"/> Pacific <input type="checkbox"/> St. Luke's			

What application(s) do you need to access through Physician Link? *(Check all that apply)*

- PCIS Online *(physicians with a PCIS account already established)*
 Radiology PACS/Imaging *(physicians only)*
 Ophthalmology PACS/Imaging *(physicians only)*
 Surgery Scheduling System *(additional information required below)*
 IBEX *(physicians only)*
 Physician Direct *(physicians with patients at St. Luke's only)*
 My Patients, Phone Directory, On Call *(additional information required below)*

Surgery Scheduling System Setup

Please list the names of all surgeons associated with this user account. For each surgeon listed below, the user will have access to their scheduling information.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

My Patients, Phone Directory, On Call Setup

Please list the names of all physicians associated with this user account. For each physician listed below, the user will have access to complete patient demographics for that physician. *(Check one)*

All Physicians in _____ Practice Group*

Fill in Practice Group Name

List Names of All Physicians in Group: _____

Individual Physician*

Physician Name: _____

**Authorizing physician signing as approver for this form must either be a member of practice group or the individual physician named above.*

Physician Link Account Setup

Name: _____
Last
First
MI.

Security Agreement

When using token to access CPMC systems I am acknowledging an understanding of and a willingness to abide by CPMC's confidentiality and information security policies. Specifically, I acknowledge that:

- ◆ All information stored on, or obtained from, CPMC systems remains the property of CPMC unless otherwise stipulated in writing, and shall be accessed and utilized in accordance with CPMC Privacy and Security Policies.
- ◆ I will not allow others to use my token to access CPMC's information or systems.
- ◆ If the token is lost or damaged, I will contact my local Help Desk at 415-600-7000 or after hours, the Sutter Health Help Desk at 916 733-3737 as soon as possible so that the token may be deactivated. Your local help desk may have replacement tokens.
- ◆ If my current role or association with CPMC and Sutter Health changes such that I am no longer authorized access to the information made available by the token, I agree to relinquish it to CPMC IT by obtaining instructions from the Help Desk at 415-600-7000.
- ◆ In the event that IT Security or management personnel within CPMC suspects a possible breach of security associated with a users account, they may, without prior notification to the account holder, suspend privileges associated with that account.
- ◆ All system access will be monitored and logged in accordance with CPMC and Sutter Health policy.
- ◆ I understand that I may have access to protected health information that is confidential and may not be disclosed except as permitted or required by law.
- ◆ I understand that I am committed to protect and safeguard from disclosure all confidential information regardless of the type of media on which it is stored (e.g. paper, micro-fiche, voice tape, computer systems).
- ◆ I agree that I will not disclose any confidential information from any record or information system to any unauthorized person.
- ◆ I have received training on HIPAA and my organization's Privacy Policies as required by 45 CFR § 164.530(b)(1).
- ◆ I UNDERSTAND I AM ACCOUNTABLE FOR ALL ACTIONS AND EVENTS RESULTING FROM THE USE OF THIS TOKEN.
- ◆ This agreement supersedes any prior agreements for information systems remote access participation.

I have carefully read the agreement above and acknowledge with my signature acceptance of the terms listed and agree to abide by them. Upon receipt of token (Ser. # _____), I understand the token is the sole property of CPMC and Sutter Health and is Non-Transferable. Replacement costs for lost or damaged tokens are the responsibility of the individual and I will be assessed the current replacement cost for its replacement.

Signature:	Date:
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Application Approval:
 I certify this employee, affiliate, or contractor is a bona fide representative of the organization indicated below under my supervision and has a valid business reason for this request. I further verify that, if applicable, a Business Associate Agreement has been signed. He/She is duly authorized by me to secure access to the CPMC System(s) outlined above. As the sponsoring physician, I agree to notify CPMC Help Desk (415-600-7000) immediately if the staff member's affiliation with my practice is terminated, so that access to the system can be terminated. In addition I agree to obtain the token and return it to CPMC.

Approving Physician Signature:	License #: (last 5 digits only)
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Print Approving Physician Name:	Date:
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CPMC IT USE ONLY

User Name	Token Serial #	Date Token Issued	Accessible Applications	Denied Applications