Access Request: Physician/Allied Health

Purpose: This form is used for Cerner Physician/Allied Health access.

- **Methodist Physicians, Allied Health please fax completed forms to Medical Staff Services at (901) 385-5225.**
- **Residents, Fellows please fax forms to Medical Education at (901) 516-8254.**

Name (as it appears on Medical License)_____ Phone # ____/_____-_____
(Please Print)

Pager/Cellular #_____/_____-_____

Last 4 digits of Social Security #_____ Birth Month _____ Birth Day _____

E-mail Address _____

Primary Methodist Hospital _____

Practice Affiliation/Name of Practice Group _____

Address _____Suite/Office #_____

City/State/Zip _____ Practice Phone # ____/_____-_____

NPI # _____ DEA # _____

Fax # for Medical Information _____ Fax # for Physician Communication _____

Please provide a secret question and answer the Information Systems Help Desk can use to identify you over the phone. The answer should only be known to you.

Identifying Question _____

Response _____

Provider Group Listing Agreement:

I agree to be included in the group provider listing, which will contain all the physicians within my practice. This will also allow access to my office staff to view clinical information on Methodist Le Bonheur patients. This list will be available to the group physicians, APNs and AHCs for use to provide coverage and rounding lists within Methodist Le Bonheur Hospitals.

Confidentiality Agreement:

You are authorized to access and utilize certain data and information only for your patients and authorized consults. Each time you access a patient's records, your entry will be identified with you and permanently recorded. By affixing your signature below, you agree to follow any and all applicable policies and procedures implemented by Methodist Healthcare regarding the privacy and security of protected health information as that term is defined in 45 C.F.R. Parts 160 and 164. You also agree to take responsibility for the confidentiality of your passwords to gain access to such information. You also agree to comply and shall require all of your employees and Business Associates to comply, with all applicable federal and state laws, rules and regulations, including, but not limited to, the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") regarding the privacy and security of such information.

Practitioner's Name _____ Signature_____ Date ___/___/___
(**REQUIRED**) (Please Print)

For Medical Staff Services Use Only

1.Practitioner ID _____ ☐ Physician ☐ Resident ☐ Pediatric Resident ☐ Allied Health

2.Name as it appears in Cactus: _____

3.Cerner Role: _____

4. ☐ Complete setup and activation immediately OR ☐ Practitioner is awaiting Board approval

5. If applicable, please check: ☐ Cardiologist ☐ CV Surgeon ☐ Neurosurgeon

6. If this is a request to change information, please note the changes here _____

_____

7. Director/VP Signature _____ Date ___/___/___ Revised 11/05/12