Security Access Agreement

Thank you for your interest and we look forward to offering you this service.

Facility Contact Information

Facility: ***South Texas Health System***
Information Services Department
Facility Contacts: ***Noe Alvarado***
Karolyn VanBuskirk
E-Mail: ***STHSPhysicianITSupport@uhsrgv.com***

Customer Support Center: ***(956) 388-2233***

Phone No.: ***(956) 388-2245***
Phone No.: ***(956) 388-2250***
eFax No.: ***(956) 289-5100***

Physician Relations Manager: ___________________________

Account Information

Date: ________________________________

Account Name: ____

Clinic/Group Name (if applicable): ____

Street Address: ____

City: __________________________________ State: ________ Zip: __________________

Office Phone: ___________________________ Office Fax: ______________________________

Office *Encrypted* Email Address: ____

Primary Office Contact Name: ____

Title: ____

Email: ____

Secondary Office Contact Name: ____

Title: ____

Email: ____

Type: ☐ Physician ☐ Billing Service ☐ Vendor Support ☐ Consultant ☐ Other__________

Office IT Support Contact:

Name: ___________________________________ Phone: _______________________

Email Address: ____

Is your technical support in-house or contracted? ☐ In-house ☐ Contracted

Service(s) Requested and Reason for Request

(TO BE COMPLETED BY THE REQUESTER)

Check all that apply

Services Requested:

☒ **FUSION (Cerner)** – Cerner is an integrated electronic medical records system (EMR) that enables physicians, nurses and other authorized users to share data and streamline processes across an entire organization. An on-line electronic chart displays up-to-date patient information in real time, complete with decision-support tools for physicians and nurses. Simple prompts allow swift and accurate ordering, documenting, and billing.

PACS – Enables access to digital images such as x-rays, and scans with access to patient's information and ability to compare with previous studies on demand.

Data Interoperability (Continuity of Care) – Assists the patient's transition of care from acute to ambulatory by automatically emailing the patient's Summary of Care record to a secure email inbox after the patient has been discharged.
Important Note: *This email must be a secure (encrypted) direct certificate email account in order to receive patient Protected Health Information (PHI).* Also, the provider must be listed as the Primary Care Physician, Referring Physician, or Follow-up Physician in the patient's inpatient record.

☐ **UHS EMR Access (Mobile App) –** A mobile solution that improves integration between providers and UHS facilities. The cell phone app will enable providers to access a patient's EMR data and receive notifications about patient events and clinical results.

☐ **Auto-fax Notifications –** Assists the patient's transition of care from acute to ambulatory by automatically faxing the patient's Discharge Summary to the office fax after the patient has been discharged.

Reason for access request:

Office/Clinic Electronic Medical Record (EMR) System: ____

EMR Technical Support Contact: ____

Phone: ________________________________ Fax: ____________________________________

Email: ____

Authorized Users

IMPORTANT NOTE: All requesters must sign a STHS Information Security and Privacy Agreement Form.

LIST ALL INDIVIDUALS WHO WILL REQUIRE ACCESS.

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

Authorized Users (cont.)

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

LAST NAME:	FIRST NAME:	MI:

TITLE:	Cell Phone:	USERNAME: (to be completed by facility Coordinator):

EMAIL:

STHS Medical Staff - Authorization

(This area to be completed by the **FACILITY** Medical Staff Office or Community Development Office ONLY)

Account Name: ____

Clinic/Group Name (if applicable): ____

Provider External Identifier: ___________________________

STHS Provider Group: ____

Credentials Status: ☐ ACT ☐ NON ☐ AHP ☐ Other_________________________

Signed: ______________________________________ Date: _________________________
(Medical Staff Office Director or designee)

Print Name: ___________________________________ Title: __________________________

STHS Facility CEO Authorization

(THIS AREA IS TO BE COMPLETED BY THE **FACILITY CEO** ONLY)

I authorize the individual(s) above to have access to the services indicated in the Service Interest section of this agreement.

Signed: ______________________________________ Date: _________________________
(CEO/Managing Director or designee)

Print Name: ___________________________________ Title: __________________________

This authorization agreement must be signed by the CEO/Managing Director of the facility, or his/her designee, where access is requested.

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