

Carecast via Citrix USER SECURITY REQUEST

*Please complete all the fields on this form for those employees you wish to have access to the **Carecast** system. Incomplete forms will be returned, thereby, delaying the process. Please print or type. A signed Information Security Agreement **MUST** accompany this request.*

Physician Office Name: _____ Address: _____

Name of Physican(s): _____

Name of Clinic Coordinator _____ Email Address _____ Phone _____

Date Needed	Last Name	First	MI	Job Title	Sex	SSN (last 4 digits)	Birthdate	Security Access 1 or 2 see below	NPI	**Office Use Only** CC/Citrix UserIDs

Clinical (1) - select if you will need access to patient look-up, lab, radiology, vital signs, allergies, transcription (includes Clerical) **OR**
Clerical (2) - select if only need access to patient lookup, demographics and insurance

AUTHORIZATION SIGNATURE: _____

DATE: _____

**Iowa Health System
INFORMATION SECURITY AGREEMENT**

Patient, financial, and other business related information in any form, electronic or printed, is a valuable asset, and is considered private and sensitive. Physicians, physician office staff, consultants, vendors, contracted agency staff, and students may have access to confidential information in the performance of their duties. Those charged with this responsibility must comply with information confidentiality/security policies in effect at Iowa Health System and its affiliates.

Therefore, in consideration of being allowed access to Iowa Health System information systems, I, the undersigned, hereby agree to the following provisions:

1. To adhere to Iowa Health System Policies and Procedures 1.MR.14 “Release of Protected Health Information – No Authorization Required”, 1.MR.15 “Release of Protected Health Information – Authorization Required” and to the physician office specific policy on release of patient medical records, if applicable, all of which I have read and understand.
2. I will not operate or attempt to operate computer equipment without specific authorization.
3. I will not demonstrate the operation of computer equipment or applications to anyone without specific authorization.
4. I agree to maintain a unique password, known only to myself, to access the system to read, edit and authenticate documents. I understand that my unique password constitutes my electronic signature and that it should be treated as confidential information. I agree not to share my password with any other individual or allow any other individual to use the system once I have accessed it. I understand that I may change my password at any time.
5. I agree to access only information and perform only computer functions as required for the performance of my duties and responsibilities.
6. I will contact my IHS sponsor if I have reason to believe the confidentiality and security of my password has been compromised.
7. I will not disclose any portion of the computerized systems to any unauthorized individuals. This includes, but is not limited to, the design, programming techniques, flow charts, source code, screens, and documentation created by employees, outside resources, or third parties.
8. I will not disclose any portion of the patient’s record except to a recipient designated by the patient or to a recipient authorized by Iowa Health System who has a “need to know” in order to provide continuing care of the patient.
9. I will report any activity, which is contrary to Iowa Health System policies or the terms of this agreement to my IHS sponsor.

I understand that I must sign this Agreement as a precondition to issuance of a computer password for access to patient information and that failure to comply with the preceding provisions will result in formal disciplinary action, which may include, but will not be limited to, revocation of system access, termination of agreements in the case of contractors, or revocation of clinical privileges in the case of medical staff members, taken in accordance with applicable medical staff by-laws, rules and regulations.

PRINT NAME _____

SIGNATURE _____ DATE _____

ENTITY _____

IHS SPONSOR _____

**PLEASE FAX SIGNED FORM TO:
515-241-7437**