

STORM EYE INSTITUTE
MUSC Ambulatory Care
Information Services (843)876-1374 (Fax)

Request For Medflow EMR Access

To: Medflow Ophthalmology EMR System Administrator
167 Ashley Avenue, MSC 676
Charleston, SC 29425
792-7509

From: _____ Ext. _____

Department/Office: _____

Date: _____

Time: _____

Fax Number: 876-1374

Number of pages including cover sheet: _____

Urgent reply requested: YES _____ NO _____

Circle as applicable: Regular or Remote Access (Supervisor's Approval Required)

Special Instructions/Comments:

Medflow Ophthalmology EMR SECURITY AGREEMENT

Purpose:

This agreement will protect the confidentiality, integrity and security of patient information in the Medflow Ophthalmology EMR. Through the use of a unique and private user identification code/username and password, and electronic signature code, all access to the Medflow EMR will be controlled and recorded.

Policy:

Healthcare information can be accessed by authorized persons to support patient care, peer review, quality improvement, risk management, reimbursement claims, clinical research, education and other legitimate requests. Any unauthorized use or disclosure of patient information is strictly prohibited. Access to various categories of patient information is based on need and defined by job title and function. Medflow Ophthalmology EMR Administration reserves the right to refuse access until proof of authorization is obtained.

Authorized persons will be issued a unique user identification code and password. The username provides appropriate access levels and serves as an electronic mechanism for tracking/auditing access and entries to Medflow Ophthalmology EMR. **THESE ARE PRIVATE IDENTIFICATION CODES AND ARE NOT TO BE SHARED WITH OTHERS OR MADE PUBLIC.** Users must **PARK** or sign off before leaving the workstation. If a user has any reason to believe that his/her sign-on code has been shared or compromised, he/she should report this to their supervisor, and contact a Medflow Ophthalmology EMR Systems Administrator to have the code changed. Upon termination of employment with MUSC or its affiliates, the user's sign-on code will be made inactive.

Failure to abide by the above policy can result in disciplinary actions including the discontinuation of computer privileges, job termination and criminal charges. (See Policy C-27 of the MUSC Medical Center Policy Manual)

Procedure:

- 1 Obtain a Medflow Ophthalmology EMR Security Agreement from your preceptor or supervisor, or by calling 792.7509. Security Agreements can be found in the Medflow Ophthalmology EMR Knowledge Base.
- 2 Complete all fields of the Medflow Ophthalmology EMR Security Agreement, then sign and date the form. Failure to do so can result in a significant delay in processing your request.
- 3 Return the completed form to a Medflow Ophthalmology EMR Systems Administrator. Forms can be faxed to 876-1374, , Attn: Medflow Ophthalmology EMR Administrator.
- 4 New codes should be available within 48 hours after your request is faxed, or 1 week after request is sent via campus mail. Employees will be contacted with their logon information.
- 5 Direct all questions or problems, i.e., forgotten password, to Medflow Ophthalmology EMR System Administrators, 792-9700. Forgotten passwords will be provided upon verification of MUSC Badge Information.

FULL Name: _____ **Credentials:** _____
(PLEASE PRINT) (RN, MD, OD, COMT, etc.)

(The user will be documenting in the system.)

Email address: _____

MUSC Badge Number: _____ **Location:** _____ **Phone:** _____ **Net ID** _____

Pager ID: _____ **Department/Specialty/Clinic:** _____ **Position:** _____

If employee has prescribing rights: MD/OD/RN: _____ NPI: _____ DEA: _____ DHEC: _____

Supervisor's Name (Printed): _____ **Phone:** _____

Supervisor's Signature: _____ **Date:** _____

I will insure employee receives adequate Medflow Ophthalmology EMR training within the department, and will inform Medflow Ophthalmology EMR Systems Administrators of any additional Medflow Ophthalmology EMR training needs employee may have.

Your signature below indicates that you have read and agree to comply with the above policy and procedure.

Employee Signature: _____ Date: _____

-----internal use only-----
PVID _____ Operator ID _____ Security level _____ RX Done _____ Group _____ DB _____ Email _____