

# JMH User Access Request Form

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The JMH UAR (User Access Request) Form is a multi-page agreement for attesting you will comply with the requirements set forth herein and a form for requesting the provisioning of access to John Muir Health (JMH) and John Muir Physician Network (JMPN) systems, including but not limited to portions of the Epic EHR System (collectively, JMH Systems). The form requires Director-level or above, approval prior to submission to JMH.

The UAR must be completed, signed and eMailed to JMH for approval and access provisioning. All requests must be submitted electronically, via eMail, and sent to [jmhlink@johnmuirhealth.com](mailto:jmhlink@johnmuirhealth.com) to begin processing.

Hard copies must be scanned to create an electronic copy and then eMailed. For questions, please contact the JMH Service Desk at (925) 941-2222.

**Note:** Complete pages 1 – 4 for new user access. **Skip to page 5 for access removal.**

## USER INFORMATION

<b>User Name</b> (Name of Individual Receiving Access)	
<b>User Title/Role</b> (e.g. Nurse Practitioner, Medical Assistant, Office Manager)	
<b>User Phone Number</b>	
<b>User eMail Contact</b>	
<b>Name of Practice or Organization</b>	
<b>Practice Specialty or Department</b>	
<b>Practice/Organization Address</b>	
<b>Practice Tax ID:</b>	
<b>Name of Requestor</b> (if different than User Name above)	
<b>Name of Authorizing Individual</b>	
<b>Title of Authorizing Individual</b>	
<b>eMail address of Authorizing Individual</b>	
<b>City, State, Zip</b>	

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<p><b>Role or Relationship to JMH</b></p> <p><u>(Please check one)</u></p>	<ul style="list-style-type: none"> <li>• Practitioner           <ul style="list-style-type: none"> <li><input type="checkbox"/> JMH Credential</li> <li><input type="checkbox"/> JMPN Credential</li> <li><input type="checkbox"/> Non-JMH or Non-JMPN Credentialed</li> </ul> </li>   <li>• Staff Member Of           <ul style="list-style-type: none"> <li>▪ JMH Credential               <ul style="list-style-type: none"> <li><input type="checkbox"/> Financial</li> <li><input type="checkbox"/> Clinical</li> </ul> </li> <li>▪ JMPN Credential               <ul style="list-style-type: none"> <li><input type="checkbox"/> Financial</li> <li><input type="checkbox"/> Clinical</li> </ul> </li> <li>▪ Non-JMH or Non-JMPN Credentialed               <ul style="list-style-type: none"> <li><input type="checkbox"/> Financial</li> <li><input type="checkbox"/> Clinical</li> </ul> </li> </ul> </li>   <li>• Third Party Billers           <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Associate of JMH</li> <li><input type="checkbox"/> Business Associate of other party</li> </ul> </li>   <li>• Health Plan Payors           <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Associate of JMH</li> <li><input type="checkbox"/> Business Associate of other party</li> </ul> </li>   <li>• Regulatory and Licensing Agencies           <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Associate of JMH</li> <li><input type="checkbox"/> Business Associate of other party</li> </ul> </li>   <li>• Coding Auditors           <ul style="list-style-type: none"> <li><input type="checkbox"/> Business Associate of JMH</li> <li><input type="checkbox"/> Business Associate of other party</li> </ul> </li>   <li><input type="checkbox"/> Other: _____</li> </ul>
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**Confidentiality Agreement:** This agreement applies to all JMH Systems. These systems contain medical records, diagnosis, test results, financials and other sensitive data of JMH patients and/or family members. This is data must be protected to comply with globally recognized standards, regulations, and business requirements, including HIPAA, HITECH, HiTrust, NIST, ISO, PCI, FTC, COBIT, and State laws.

Please **initial, in each box**, that you have read and understand each of the following provisions:

**USER INITIALS**

## JMH User Access Request Form

	1. I shall protect the confidentiality of the information contained in the JMH Systems as required by this Agreement and by applicable laws governing privacy and security of patient information, including but not limited to HIPAA and similar regulations.
	2. I shall safeguard my JMH Systems user IDs and passwords (Credentials). I will not share my Credentials with any individuals (e.g., Supervisors, Contractors, etc.) or use another individual's Credentials to access JMH Systems.
	3. I am being granted access to JMH Systems solely for the purpose of performing work-related duties. I will access the minimum amount of information authorized and necessary to perform such my work duties. I shall not use my JMH Systems account access for any personal or other purpose.
	4. If I discover or suspect my JMH System Credentials have been compromised, I will immediately notify the JMH ITS Service Desk by calling (925) 941-2222 or eMailing Support.Center@johnmuirhealth.com.
	5. JMH conducts routine access audits to ensure information accessed through JMH Systems is appropriate. I am personally accountable for any actions taken using my Credentials.
	6. JMH Systems contain confidential information and proprietary materials owned by JMH and/or JMPN and/or their respective licensors, such as Epic Systems Corp (collectively, JMH Confidential Information). I understand that JMH Confidential Information does not belong to me.
	7. I shall not use or disclose any JMH Confidential Information with other individuals unless required to perform my work. If any such use or disclosure is required, I will follow the applicable procedures and instructions of my Supervisor or Director.
	8. If I receive a request or demand from any person or organization other than JMH, or JMPN for JMH Confidential Information or access to the JMH Systems, I shall immediately notify the JMH Privacy Officer at (925) 941-2688 and my Supervisor.
	9. I will not print, store, process, transmit, download or make copies of any information, software or screen shots accessed in the JMH Systems, except for copies required to document the treatment in the medical record maintained by a practice office or in the financial records maintained by a practice office to obtain payment for such treatment.
	10. I understand that failure to comply with these requirements may result in revocation of my JMH Systems user account and other actions by JMH, and/or JMPN, including referral to appropriate law enforcement agencies.
	11. Upon termination of my employment, service or engagement with the affiliated practice or organization or entity, I will return my Credentials to the JMH Systems (e.g., tokens) and all copies of documents containing JMH Confidential Information in my possession or under my control.
	12. I have completed my organization's HIPAA Privacy & Security compliance training, and I will abide by to the applicable policies and procedures as they apply to accessing confidential information.

# JMH User Access Request Form

By signing below, I agree to comply with the requirements set forth herein. Please allow 10 business days for access to be granted.

<b>By:</b>		<b>Title:</b>	
<b>Print Name:</b>		<b>Date:</b>	

**Authorization Required**

By signing below, I am authorizing the above individual to have access to any information in JMH and/or John Muir Physician Network electronic information systems, including but not limited to portions of the Epic EHR System (collectively, JMH Systems).

<b>Authorizer - Print Name:</b>	<b>Title:</b>
<b>Authorizer Signature:</b>	<b>Date:</b>
<b>Relation to Requestor:</b>	

***JMH*** ***Only*** ***Below***

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<b>JMH ITS Director USE ONLY:</b>	
<b>Director - Print Name:</b>	<b>Title:</b>
<b>Director's Signature:</b>	<b>Date:</b>
<b>JMH ITS SERVICE DESK USE ONLY:</b>	
<b>Rec'd By (Sign):</b>	<b>Title:</b>
<b>Print Name:</b>	<b>Date:</b>

# JMH User Access Request Form

A **JMH UAR** (User Access Request) Form must be submitted to **remove** access of a non-JMH employee to any information in JMH Systems).

The Affiliated Partner Director will notify the ITS Service Desk by the submission of this form. This form must be forwarded to the ITS Service Desk mailbox [ITServiceDesk@johnmuirhealth.com](mailto:ITServiceDesk@johnmuirhealth.com). For questions, please contact the JMH ITS Service Desk at (925) 941-2222.

**USER INFORMATION (*access to be removed*)**

<b>User Name</b>	<b>User Title/Role</b>
<b>User Phone Number</b>	<b>User eMail Contact</b>
<b>Name of Practice or Organization</b>	<b>Name of Authorizing Individual</b>
<b>Reason or Comment</b>	<b>Phone number of Authorizing Individual</b>
<p><b>Remove access to EpicCare Link or Plan Link for above User as of this date/time (<i>must be entered</i>):</b></p> <p style="text-align: center;">Date: ___/___/___ Time: _____ am pm (circle) OR Immediately</p>	

**Director Requesting User Removal**

By signing below, I am authorizing the removal of access of above individual to any information in JMH Systems).

<b>Director Print Name:</b> _____	<b>Title:</b> _____
<b>Director Signature:</b> _____	<b>Date:</b> _____

**JMH Only Below**

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JMHS ITS SERVICE DESK USE ONLY:	
<b>Rec'd By (Sign):</b> _____	<b>Title:</b> _____
<b>Print Name:</b> _____	<b>Date:</b> _____