Indiana University Health

IU Health Agreement for EMR/System Access or Badge Access

3rd Party Access for Non-IU Health Users

Date Access to IU Health EMR/Systems is **Requested**:	Date Access is to Expire (unless auto expiration*):
_____ / _____ / _____	_____ / _____ / _____

*Access all to IU Health EMR/Systems will **automatically expire** for any of the following reasons:

- **January 1st** each calendar/fiscal year (unless you have re-submitted this form for reprovisioning of access and annual HIPAA training completion by **December 1st**)
- **90 days** following non-use of your login credentials
- **Any time at the discretion of IU Health**

Reason for Requesting Access:	**Check *all* that apply:** ☐ **Treatment** ☐ **Payment** [FN-1] ☐ **Education/Training** ☐ **Research** ☐ **Business Associate** performing services on behalf of IU Health involving Protected Health Information (PHI) (*attach* Business Associate Agreement, if available) ☐ **Health Care Operations**[FN-2] **(*Description required*):** _____ _____ ☐ **Other (*Please provide details as to the reason for requesting access*)** _____ _____ _____	If access for "**Research**", then provide: **Study Name(s):** _____ _____ **Protocol #(s):** _____ _____ **Research access:** please provide one or more of the following is required for access (check ***all*** that apply): ☐ Research pursuant to signed patient Authorization(s) ☐ Research pursuant to Institutional Review Board (IRB) Waiver of Authorization(s) (*attach*, if available) ☐ Preparatory to Research (no PHI may be removed from IU Health)
Contact Information: By signing below, you are permitting IU Health to utilize this information for communication purposes.	**Your Home Address and Contact Information:** Name: _____ Preferred First Name:_____ Previous Name (*if applicable*):_____ Date of Birth:_____ Address: _____ _____ City, State, Zip:_____ County of Residence:_____ Personal Email: _____ Telephone: _____ Have you ever worked for IU Health previously? _____ Are you a current IU Health employee?: _____ Indiana University ID # (*if applicable*): _____	**Your Employer/Company/Institution's Information (Affiliate Information):** Name: _____ _____ Address: _____ _____ City, State, Zip:_____ Telephone:_____ Supervisor/Preceptor (name): _____ Email: _____

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IU Health Leader who can validate you are entitled to request access (If access is for treatment purposes as a provider, then list IU Health facilities where credentialed)**:** Name: _____Email (if known):_____	
Please list out the IU Health locations/facilities where you are working or credentialed with the first location listed being your primary location.	IU Health Locations/Facilities: _____ _____ _____
Project Information: If you are working on a project, please name the project(s) you are working on for the required access and the date the project is expected to end. (Attach one list for all staff, if applicable)	_____
Remote Status: If you will ***not*** be on-site at an IU Health location or facility, please check this remote worker box:	☐ **By checking this box, you are certifying that you will not be entering any IU Health locations/facilities. And you understand that should this change at any time you will update your IU Health Sponsor or IU Health Line Manager allowing your access to remain active.**

[FN-1]**Payment** means accessing only the *minimum necessary* PHI to determine coverage of benefits under health plan; to obtain or provide reimbursement for the provision of health care; risk adjusting; billing, claims management, collection activities; review with respect to medical necessity or justification of charges; and utilization review, including precertification and preauthorization.

[FN-2]Access to PHI for **health care operations** means (i) conducting quality assessment and improvement activities; population-based activities relating to improving health or reducing health care costs, case management and care coordination; reviewing competence and qualifications of health professionals; and fraud and abuse detection; (ii) only the *minimum necessary* PHI is accessed; and (iii) both IU Health and the other Covered Entity have a relationship with the patient/enrollee, the PHI accessed pertains to that relationship and no PHI is accessed prior to the individual being enrolled in the health plan when the Covered Entity is a health plan.

By signing below, you are confirming that (1) your above responses are true and accurate, (2) de-identified information cannot be used, and (3) you agree to fully comply with all IU Health policies and procedures and applicable federal and state law governing Data (as defined in the Information Security Responsibility Statement) and protected health information (PHI)), including without limitation HIPAA.

_____ _____ _____

Printed Name – User Signature Date

_____

Affiliation Employer/Institution's Name (if not IU Health)

_____

Affiliation Employer Manager's Name or Institution's Faculty Name

_____ _____

IU Health Employee # (if known or Username) Indiana University ID # (if applicable)