5501 S. McColl Road, Edinburg, TX 78539
PH: (956) 362-7161 Fax: (956) 362-7167
Email: DHRCRED@DHRHEALTH.COM

Referring Provider EMR Access Application

Clinician Information

Clinician Name:
Specialty:
Individual NPI:
TMB License#:
Clinician Email:
Clinician Personal Cell: (Required for Multifactor Authentication)
EMR Direct Email Address: (If Available)
For Allied Health Only:
Title:
TBN:
Supervising Physician:

Primary Practice Location

Practice Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Office Manager Name:		
Office Manager Email:		

Group Practice Information

Group Name:

DHR MEDICAL STAFF OFFICE USE ONLY:

User ID: _____ Medical Staff Approval: _____ Date: _____	☐Non-Staff Referring with EMR Read Only Access	☐Non-Staff Referring

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DHR Health Electronic Protected Health Information/ Confidential Information Guidelines

DHR Health (DHR) is committed to protecting the privacy and security of individually identifiable information (including all patient personal, health, business and financial information), DHR organizational information, and all other information of a confidential nature for DHR and its affiliates (collectively known as "Confidential Information"). Each authorized DHR system user who accesses DHR Confidential Information or DHR computerized data holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access Confidential Information must read and comply with all DHR Policies. As a condition to receiving access to such private and confidential information, I, the undersigned, agree to comply with the following terms:

1. I will not, at any time during or after my affiliation with DHR, disclose Confidential Information to which I have or had access in any form (i.e., electronic media, paper, microfilm, verbal etc.) to any unauthorized individuals.

2. My computer log-in is equivalent to my LEGAL SIGNATURE and I will not share or disclose this code to anyone or allow anyone to access any application using my log-in.
3. I will comply with DHR procedures in the assignment and format of my user password. If I lose or forget my password, or desire to have it changed, I will immediately notify DHR's IS Department for action.

4. I am aware that any user IDs or passwords assigned to me are to be used only by me and are not to be divulged to any other party. If I feel that my user ID or password has been used by another party, I will notify DHR's IS Department immediately and seek an immediate password change. The IS Department will investigate and take corrective action if needed.

5. I will not enter transactions in any computer system under another individual's user ID and/or password.

6. I will use the information systems facilities of DHR, DHR information, confidential patient information and third-party proprietary information only in a manner consistent with my job functions, and for conducting legitimate patient/ physician treatment or services.

7. I will not access or request data on patients for whom I have no clinical/professional relationship and/or legitimate business purpose. Further, I will not attempt to gain access to information or computerized facilities to which I am not specifically authorized or otherwise have a no “clinical need to know”. I will access only what is needed to treat or coordinate care.

8. I will not access any medical record that I am not specifically authorized to access, including but not limited to the medical record of any family member, friend, or co-worker.

9. I will utilize and access only the minimum amount of information necessary for performance of my job or treatment of any patient under my medical supervision.

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10. I will respect the confidentiality of any reports and handle, store and dispose of these reports appropriately.

11. I will utilize the privacy curtain (lock your computer) or suspend access when leaving a workstation to prevent unauthorized access.

12. I will not install or operate any non-licensed software on any DHR computer.

13. I will comply with all policies and procedures and other rules relating to confidentiality of information and log-ins.

14. I understand it is against DHR policy to electronically communicate clinical information to patients or others outside of the local network.

15. I understand that if I share my user ID/password, use someone else's user ID/password, or fail to comply with this Agreement, I will be committing a breach of hospital policy. I understand that any breach of hospital policy will subject me to established disciplinary processes and actions as outlined in DHR policies, including medical staff bylaws if applicable.

16. I understand that DHR retains the right to seek prosecution when misuse of its information resources is suspected. I understand that confidential information resources are protected in every form, such as written records and correspondence, oral communication, and electronic information system and acknowledge my responsibility in preserving its confidentiality.

17. I understand that DHR must report any inappropriate or unauthorized disclosure and/or access of Patient Confidential Information to the particular patient and the appropriate federal government agency as required by law.

Security Agreement: I have carefully read the policies/guidelines attached and acknowledge that my signature affixed to this security agreement constitutes acceptance of the terms listed therein and an agreement to abide by them. Specifically, I have carefully read the DHR Electronic Protected Health Information (EPHI)/ Confidential Information Guidelines contained above. I understand that my use of DHR EPHI/Confidential Information will be monitored to ensure compliance with this Agreement. I further understand that any violation of the terms of this agreement may subject me to loss of privileges to access information, termination of my affiliation with DHR, or other remedies available to DHR including civil or criminal penalties, as provided by federal and state law.

**I agree to the DHR EPHI/Confidential Information Guidelines.

Signature: _____ Date: _____

Instructions: Complete form, print, sign and email to DHRCRED@DHRHEALTH.COM