New EpicCare Link Organization Access Request Form

St. Charles Health System and affiliated Connect partners allow limited access to our electronic clinical records in accordance with SCHS policy, state and federal law, including HIPAA and the HITECH Act.

Approval is based on the sufficiency of the responses you provide…please be as specific as possible.

Office/Organization (Facility) Name: _____

What is the name, role, and contact information for the person that will be the EpicCare Link site administrator?

Name: _____

Role: _____

Contact Info: _____

Please list the organization(s) with which you will be affiliated?

- ☐ Bay Area Hospital
- ☐ Bay Clinic
- ☐ Harney District Hospital and Clinics
- ☐ North Bend Medical Center
- ☐ SCHS – St Charles Health System
- ☐ Volunteers in Medicine (VIM)

If you are requesting access to the full patient medical record, please provide the name and contact information for your Medical Director:

Medical Director Name: _____

Medical Director Contact Information: _____

If you work with any departments at the entity or entities selected above, please list them here:

_____

_____

Please state your reason for requesting electronic access to the medical record:

_____

_____

What type of information do you need to access and for what purpose?

_____

_____

What type of license do you operate under? (ie, skilled nursing, long-term care, medical doctor, chiropractor, etc.)

_____

(continued on back)

To help us evaluate your request, please check all of the following that apply and provide an explanation where required:

TREATMENT:

- ☐ We have one or more credentialed providers at our organization
- ☐ We admit or refer patients to/from our organization
- ☐ We order Labs and/or Diagnostic imaging from the entity or entities selected above
- ☐ Other (explanation required) _____

PAYMENT:

- ☐ We bill and/or provide operational support for a credentialed physician/office and have a business associate agreement (BAA) in place with that office
- ☐ We conduct state or federally required audits (HEDIS, Risk Adj., CCO, etc.) and need access to EHR records for the period of _____ to _____ (Note: This period may not exceed 90 days)
- ☐ Other (explanation required _____

OPERATIONS:

- ☐ We provide care coordination/case management for patients who have a medical record
- ☐ We provide quality and outcomes assessments for patients who have a medical record
- ☐ We provide peer review for shared patients who have a medical record
- ☐ Other (explanation required) _____

ADDITIONAL INFORMATION ABOUT YOUR ORGANIZATION (please check all that apply):

- ☐ We are a covered entity as defined by HIPAA (See www.cms.gov, "Are You a Covered Entity?")
- ☐ We have a contract or BAA in place with the entity or entities selected above
- ☐ We have a HITECH compliant breach notification process in place

Will any of the SCHS information you access be disclosed to a third party (excluding any federal or state agencies as required by law)? ☐ No ☐ Yes

If Yes, explain _____

Name of person completing this form: _____

Email Address: _____

Phone: _____