GALEN
MEDICAL GROUP

External EMR Security Access Form

User Information	
Printed Name:	
Job Title:	
Employed By:	
Phone:	

System Information	
☐ **EMR**	☐ **Practice Management**
☐ **VPN**	☐ **Other _____**
Dates Requesting Access: Start Date: _____ End Date:_____	

Approving Authority Information and Authorization	
Printed Name:	
Job Title:	
Email Address:	
Phone:	
Signature:	

I hereby acknowledge that my Employer requires me to comply with all applicable privacy laws with respect to Protected Health Information (PHI) to which I am being granted access on behalf of my Employer. I also understand that Galen is required by the new HIPAA Privacy Rule to restrict disclosure to my Employer if a patient pays entirely out-of-pocket for a particular service and requests that Galen so restrict disclosure of the PHI related to that service. To the extent I may inadvertently receive and recognize PHI as being so restricted, I agree to inform Galen and to curtail further use or disclosure to the extent reasonable under the particular circumstances.

Furthermore, I will not disclose my personal User ID to others and understand that use of any Galen User ID is monitored concurrently and always subject to retrospective audit.

_____ _____

Signature **Date**

***Employer must be a Covered Entity, have entered into a Business Associate Agreement (BAA) with Galen, or have entered into a subcontractor BAA with the Covered Entity or with the primary business associate of Galen.**