HealthCare.

Complete and return: Fax: **859-257-4148** Email: **lizcolumbia@uky.edu**	**UK HealthCare Information Security Referring Care Provider Request Form**	**Please Note:** Information must be completed for processing. . . **Please PRINT clearly.**

Date: _____ (mm/dd/yyyy) Your Date of Birth: _____ / _____ / _____

Previous UK Student or Employee: ☐ **Yes** ☐ **No** **If yes – previous name:** _____

Previous UK Portal Access: ☐ **Yes** ☐ **No** **If yes – previous facility name:** _____

Name: _____ _____ _____ ☐ M ☐ F

First **M.I.** **Last**

Please circle your title: MD DO APRN PA-C* RN* Office Staff* Referral Coordinator* Other* ED Physician _____

NPI # (If applicable)_____ Email Address (**REQUIRED**) _____

Applications will not be submitted without an email address provided.

***NOTE**: If you are not an MD/DO/APRN you are required to have one who is trained on the portal to sign-off for you. Please indicate the name of the MD/DO/APRN provider you are associated with: (They will also need to sign at the bottom.)
Provider's Name: _____ Provider's NPI: _____

Primary Office Location Information: (<u>All Fields Required</u>)

Facility/Practice Name: _____ Facility NPI#:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Fax: _____

Site Administrator Name: _____

Remote Access Services for Referring Physicians Access Disclaimer

- The UK HealthCare Physician Portal is designed to provide a single point of access to information, tools and services specifically for the needs of referring providers. I will only look up information on patients for whom I have direct responsibility.
- The UK Physician Portal is a private, secure network available only to authorized users. All users must register to receive a personal user ID and password, issued by UK HealthCare Information Technology Services.
- You assume full responsibility for using the information on the portal, and you understand and agree that UK HealthCare and its affiliates are not responsible or liable for any claim, loss, or damage resulting from its use by you or any user. UK HealthCare does not warrant that access to the portal will be error or virus-free.
- By choosing to use the UK Physician Portal you acknowledge and agree to the terms of this Disclaimer. We reserve the right to modify these terms and policies at any time.

Your Signature :_____

Approval is Required from the Provider (MD, DO, OD, DPM, DMD, APRN) (See Above ***Note**):

Provider's Name (PRINT): _____

Provider's Signature: _____

If you need assistance, please contact your liaison or **Liz Robertson** at: **859-323-0736** or **lizcolumbia@uky.edu**

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Referring Care Provider Confidentiality Agreement

Name: _____
First M.I. Last

Date of Birth: _____/_____/_____ UKID:_____
mm /dd/yyyy To be completed by UKHC IT

I agree to keep UK HealthCare patient information confidential by observing the following:

1. I will protect my password from use or theft by others.
2. I will sign off the system when I leave the workstation and not allow others to use my access.
3. I will only look up information on patients for whom I have direct responsibility.
4. I will not look up my own medical information.
5. I will share patient information only with people who have a right to access the information in order to perform their job function.
6. When sharing information with people who have a right to access the information in order to perform their job function, I will ensure that I am in a private setting where others can not hear or see the confidential information.
7. I will follow all University of Kentucky, Medical Center, Hospital and department rules of conduct whenever I use e-mail.
8. I will password protect my personal digital assistant device that contains patient (or confidential) information.
9. I will not disseminate confidential information from my home computer without appropriate authorization for release of information.
10. I will dispose of confidential information properly in accordance with all applicable policies.
11. I understand that audits will be performed on computer usage to ensure compliance with all computer related policies and this confidential agreement.
12. I will follow other specific confidentiality rules for special situations. When departments have standards more stringent than this statement, I will abide by their standards.
13. I will comply with the enterprise electronic signature policies and protect my electronic signature when issued to me from use or theft by others.
14. I understand that UK HealthCare has the right to take appropriate action up to and including termination of my access for breaches of misuse of Protected Health Information.

Please initial you have read and agree: _____ Date: _____

This form is kept on the file with UK HealthCare Information Security

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XIII. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for access to UK's clinical access system ("Hospital"), I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as described in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, an authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge that the medical record is the property of the University of Kentucky HealthCare. UK HealthCare is the official custodian and repository of these records. As such, I agree not to release any of these records to any third party. I acknowledge that all requests for release of information must be submitted in writing to UK HealthCare.

I acknowledge and agree that: (1) access to UK's clinical access system is not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in UK IT's policies and procedures; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to hold all information as confidential; (5) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for access to UK's clinical access system, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain access to UK's clinical access system (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

I hold current, active privileges at:

(If not applicable, please leave Hospital Name, City and State blank. Print Name, Sign and Date)

Hospital Name _____ City _____ , State: _____

Information contained in attached documents is accurate and complete to the best of my knowledge. Any misrepresentation, misstatment, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status granted in reliance upon it.

Applicant's Name (printed) : _____

Applicant's Signature : _____

Date: _____