Methodist Healthcare Information Systems
Access Request: Medical Student

Please return forms to Andrew.Gienapp@mlh.org (PDF only, no jpegs or other images) or fax to (901) 516-2771.
• Training on system use is mandatory prior to account activation.
• **INCOMPLETE FORMS WILL NOT BE PROCESSED**
• If form is handwritten, it must be **clear and legible**. **DO NOT** WRITE IN CURSIVE.

Name, Last: ______________________ **First:** ______________________ **MI:** ________

Primary/Cell Phone: ______________________ **Alternate Phone/Pager:** ______________________

Birth Mo: ______________ **Birth Day:** ________ **Last 4 Digits of Social Security No.:** __________

M3 or M4: ______ **E-mail Address Provided by Medical School:** ______________________

Rotating with which Memphis Residency Program/Specialty (if a visiting student): ______________

If completing a visiting rotation, list dates of rotation from ______________ **to** ______________

Primary Methodist Hospital: ______________________________________

Medical School Affiliation: ______________________________________

If not UT Medical School, Student Affairs Phone No.: ______________ **Fax No.:** ______________

Please provide a secret question and answer the Information Systems Help Desk can use to identify you over the phone. The answer should only be known to you. (i.e., the name of your first pet, the high school from which you graduated.)

Identifying Question: ______________________________________

Response: ______________________________________

Confidentiality Agreement:

You are authorized to access and utilize certain data and information only for the patients you are studying in the course of your medical education program at Methodist Healthcare. When in doubt as to whether or not information should be obtained, it is your responsibility to discuss the matter with your supervising physician. Each time you access a patient's records, your entry will be identified with you and permanently recorded. By affixing your signature below, you agree to follow any and all applicable policies and procedures implemented by Methodist Healthcare regarding the privacy and security of protected health information as that term is defined in 45 C.F.R. Parts 160 and 164. You also agree to take responsibility for the confidentiality of your passwords to gain access to such information. You also agree to comply with all applicable federal and state laws, rules and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regarding the privacy and security of such information.

Name (Print): ______________________ **Signature:** ______________________ **Date:** __________

For Medical Education Use Only

Cerner Role: ☐ Medical Student ☐ Need PACS

If this is a request to change information (e.g., name, role in Cerner or PACS), please note the changes here:

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Director/VP Signature: ______________________ Date: ______________

For Information Systems Use Only

Remedy Ticket No.: ______________________ LogIn ID: ______________

Completed by: ______________________ on: ______________

Version 5/25/17