Cornerstone Regional Hospital
Security Access Agreement

Thank you for your interest and we look forward to offering you this service.

Facility Contact Information

Facility: ***Cornerstone Regional Hospital***
Primary Facility Contact: ***Elizabeth Jasso***
E-Mail: maryelizabeth.jasso@uhsinc.com
Secondary Facility Contact: ***Crystal Lopez***
E-Mail: crystal.lopez@uhsrgv.com

Customer Support Center: ***(956) 388-2233***
Phone No.: ***(956) 972-6423***
Fax No.: ***(956) 289-5345***
Phone No.: ***(956) 972-6425***
Fax No.: ***(956) 618-4242***

PLEASE PRINT ALL INFORMATION

Account Information

(TO BE COMPLETED BY THE REQUESTER)

Date:___________________________________

Account Name: ____

Group (if applicable): ____

Street Address: ____

City: ______________________________ State: ________ Zip: ________________

Office Phone:_______________________ Fax: ______________________________

Email Address: ____

Office Contact 1: _____________________ Title:_______________________

Office Contact 2: _____________________ Title: ______________________

Type: ☐ Physician ☐ Billing Service ☐ Vendor Support ☐ Consultant ☐ Other__________

Technical contact:

Name: _______________________________ Phone: ______________________

Email address: ____

Is your technical support in-house or contracted? ___________________________

Service Requested and Reason for Request

(TO BE COMPLETED BY THE REQUESTER)

Check all that apply

Services Requested:

☐ **FUSION (Cerner)** – Cerner is an integrated electronic medical records system that enables physicians, nurses and other authorized users to share data and streamline processes across an entire organization. An on-line electronic chart displays up-to-date patient information in real time, complete with decision-support tools for physicians and nurses. Simple prompts allow swift and accurate ordering, documenting, and billing.

☐ **PACS –** Enables access to digital images such as x-rays, and scans with access to patient's information and ability to compare with previous studies on demand.

Reason for remote access: ____

____

(other facility specific applications)

Environment Specifications

I have reviewed the requirements (as indicated in the attachment appropriate to my request) for access and confirm that my environment meets the minimum requirements based upon the service requested.

Initial: Yes_______No _________

Authorized Users

NAME AND TITLE TO BE COMPLETED BY THE REQUESTER.

User ID to be completed by the Facility Coordinator(s).

LIST ALL INDIVIDUALS WHO WILL REQUIRE ACCESS.
PLEASE PRINT LEGIBLY- INFORMATION USED FOR ACCOUNT SETUP.

NAME	TITLE	USER ID (To be completed by Facility Coordinator)

NOTE: All authorized users must sign a UHS Information Security Agreement. These signed agreements should be attached to this form prior to submission.

Authorized Users (cont.)

NAME AND TITLE TO BE COMPLETED BY THE REQUESTER.

User ID to be completed by the Facility Coordinator.

LIST ALL INDIVIDUALS WHO WILL REQUIRE ACCESS.
PLEASE PRINT LEGIBLY- INFORMATION USED FOR ACCOUNT SETUP.

NAME	TITLE	USER ID (To be completed by Facility Coordinator)

NOTE: All requesters must sign a UHS Information Security Agreement. These signed agreements should be attached to this form prior to submission.

Authorized Users (cont.)

NAME AND TITLE TO BE COMPLETED BY THE REQUESTER.

User ID to be completed by the Facility Coordinator.

LIST ALL INDIVIDUALS WHO WILL REQUIRE ACCESS.
PLEASE PRINT LEGIBLY- INFORMATION USED FOR ACCOUNT SETUP.

NAME	TITLE	USER ID (To be completed by Facility Coordinator)

NOTE: All requesters must sign a UHS Information Security Agreement. These signed agreements should be attached to this form prior to submission.

Medical Staff - Authorization

(This area to be completed by the **FACILITY** Medical Staff Office or Community Development Office ONLY)

Physician Name: ____

Group Name: ____

Provider Code:_____________________ Group Code: _________________________________

I authorize the individual(s) above to have access to the services indicated in the Service Interest section of this agreement.

Signed:_____________________________________ Date: __________________________________
(Medical Staff Office Director or designee)

Print Name: _________________________________ Title: __________________________________

Facility CEO Authorization

(THIS AREA IS TO BE COMPLETED BY THE **FACILITY CEO** ONLY)

I authorize the individual(s) above to have access to the services indicated in the Service Interest section of this agreement.

Signed:_____________________________________ Date: ___________________________
(CEO/Managing Director or designee)

Print Name: _________________________________ Title: ___________________________

This authorization agreement must be signed by the CEO/Managing Director of the facility, or his/her designee, where access is requested.

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