Kansas Health Information Network
KHIN CareAlign User Access Request Form

- ☐ New Account
- ☐ Change Account
- ☐ Delete Account

Employer: Via Christi (*If you are not employed by Via Christi, please contact Allen Laramore, Wichita Health Information Exchange Project Manager, for access: allenlaramore@whie.net)*

Last Name: ______________________ First Name: ______________________ Middle Initial: ______

Credentials or Title: ________________ Employee ID #:___________ Phone Number: ____________

E-mail Address: ____________________________

** For Secure Clinical Messaging (Direct): An alert will be sent to the email account of your choice to notify you there is a message in KHIN CareAlign. No PHI will be in the email alert. This will be automatically set up for all Providers.*

Select your location:

- ☐ Via Christi Hospitals – Wichita (or St. Teresa)
- ☐ Via Christi Clinic

Role:

- ☐ Physician
- ☐ PA/APRN
- ☐ Nurse/MA
- ☐ Clinical Staff
- ☐ Physical Therapist
- ☐ Laboratory
- ☐ Radiology
- ☐ Dentist
- ☐ Optometrist
- ☐ Licensed Social Worker
- ☐ Substance Abuse Counselor
- ☐ Health Information Technology
- ☐ Health Information Management
- ☐ Administration

Special Permissions:

- ☐ Audit (for Administration role only, if your responsibilities include performing HIPAA or compliance audits)
- ☐ Health Information Management (for Health Information Management role only, if your responsibilities include document maintenance)

Employee Signature: ______________________________________Date:__________

Manager or Medical Staff Representative Signature:_____________________________ Date:__________

Required for Providers

NPI:________________ Practicing City:_______________ Provider Specialty:________________

VIA CHRISTI HEALTH, INC. AND AFFILIATED MINISTRIES AUTHORIZED USER CONFIDENTIALITY AGREEMENT MUST BE SIGNED AND ACCOMPANY THIS FORM

PLEASE FAX COMPLETED FORMS TO THE VC IT SERVICE CENTER @ 316.350.3861

OR E-MAIL IT TO HELPDESK@VIA-CHRISTI.ORG

REVISED: 10/30/2012

** All Access requests are processed through the KHIN help desk and may take up to 5 business days to complete**

VIA CHRISTI HEALTH, INC.
AND AFFILIATED MINISTRIES
AUTHORIZED USER
CONFIDENTIALITY AGREEMENT

Pursuant to the Participation Agreement (the "Agreement") entered into by and between Via Christi Health, Inc. and/or Affiliates ("VCH") and the Kansas Health Information Network ("KHIN"), which includes the Wichita Health Information Exchange, all VCH Authorized Users, as defined by the Agreement, agrees to the confidentiality provisions provided below:

AUTHORIZED USER:

I acknowledge that during the course of performing my duties as an Authorized User as defined by the Agreement, I may have access to, use, or disclose confidential health information when performing services on behalf of VCH and its patients and residents. As such, I hereby agree to handle such information in a confidential manner at all times and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my duties by providing service on behalf of VCH and its patients and residents.

B. I will request, obtain or communicate confidential health information only as necessary to perform my duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish such duties.

C. I will take reasonable care to properly secure confidential health information on my electronic device and will take steps to ensure that others cannot view or access such information. When I am away from my workstation and/or electronic device or when my tasks are completed, I will log off my electronic device or use a password-protected screensaver in order to prevent access by unauthorized users.

D. I will not disclose my personal password(s) to anyone without the express written permission of my department head or record or post it in an accessible location and will refrain from performing any tasks using another's password.

E. I will assist VCH to document those disclosures of confidential information, which include a patient's and/or resident's personal health information, that are required by law or regulation to be documented, including those authorized by patients and/or residents of VCH and any accidental disclosures, in accordance with the VCH Accounting of Disclosure Policy.

I understand that as an Authorized User of VCH, I have an obligation to complete the health information exchange Confidentiality and/or HIPAA compliance training as required by KHIN, and in signing this Agreement, I confirm that I have completed such confidentiality training prior to being designated as an Authorized User.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or a violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment.

Authorized User Signature:____

Authorized User Printed Name:____

Date:________________________________

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