Authorization for EMR Access

Please select whether you will require Full or Limited Access

☐ Full Access

Employee’s Name: _____________________ Title: _____________________

☐ New Hire  ☐ Position Change

Start Date: _____________________ End Date: _____________________

Level of Access Required: ☐ Physician  ☐ Nurse  ☐ Staff  ☐ Admin

☐ Limited Access

Requestor’s Name: ____________________________________________

Date Access Needed: _________________ Termination Date: ____________

Reason for Request to Access EMR: ________________________________

_____________________________________________________________

Scope of Request (Include specific records, scope of review, amount of time needed in the system): ________________________________

_____________________________________________________________

_____________________________________________________________

Supervisor’s Approval

Signature: _____________________ Date: _________________

Compliance Approval

Signature: _____________________ Date: _________________

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