PennState Health

Information Technology Account Request Form
Penn State Health Provider Portal/Provider Portal PLUS

1. All requests must have Sections 1 through 3 fully completed prior to submission.
   a. Applicant completes Section 1 & 2 then signs and dates Section 4.
   b. PSH/COM sponsor reviews Section 1 & 2 for completion then completes Section 3 and signs Section 4.
   c. **Submit forms to**: HIMProviderPortalGroup@pennstatehealth.psu.edu
2. Account request form will be returned to the sponsor if *all fields* are not completed and all signatures are not provided.

Section 1: Applicant's Personal Information

Penn State Health Employee? YES / NO (Circle One)

Legal Last Name: _____
Legal First Name: _____ Preferred First Name: _____
Middle Name: _____
Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Do you have a current/previous PSU ID?

☐ No
☐ Yes; please provide PSU ID: _____

Did you have a current/previous relationship with PSH/COM using a different name?

☐ No
☐ Yes; please provide previous name(s):_____

Section 2: Practice Information

Practice name: _____
Practice Contact Name:_____
Practice Contact email _____
Practice Contact phone: _____

Add'l Practice Name: _____
Add'l Practice Contact name: _____
Add'l Practice Contact e-mail: _____

Add'l Practice Name: _____
Add'l Practice Contact name: _____
Add'l Practice Contact e-mail: _____

Section 3: Access Requested

Type of access: (circle one): New ***or*** Change

☐ **Power Chart** – (**circle one**) Provider Portal / Provider Portal PLUS
   ☐ Support Staff
   ☐ Provider
   ☐ RMT

☐ **Medical Imaging**

☐ **Change Name** *(will result in change of username)*
From:
To:

Section 4: Non-PSH/COM Workforce Members User Agreement/Authorization:

1. I understand that Federal and state laws (i.e. HIPAA and the Commonwealth of Pennsylvania Breach of Personal Information Notification Act) regulate the acquisition and access of protected health information and other personally identifiable information.
2. I agree to limit my access and use of my PSH Guest Access Account to minimal necessary use to accomplish authorized work in support of the continued care of our mutual patients.
3. I have previously completed a Privacy and Information Security Awareness and Education program sponsored by my agency, corporation, university and/or employer; or completed the PSH Information Privacy and Information Security Awareness and Education Program.
4. Where I demonstrate a need to know and right to know, and I am granted access to the PSH Health Information (hard copy or electronic medical records), I will take prudent and responsible measures to safeguard the information from unauthorized acquisition and access.
5. To comply with HIPAA and the Breach of Personal Information Notification Act, Title 73, Chapter 43 of the Pennsylvania Statutes, I agree to provide PSH timely notice of known or foreseeable unauthorized acquisition and access of individuals' protected information (i.e. a loss or breach of data entrusted to me or my employer).
6. Where I am authorized to create, review, update, store, transmit or exchange PSH Protected Health Information, I will implement good information security controls to safeguard the confidentiality, integrity and availability of the data as specified under the United States Health and Human Services HIPAA Privacy and Security rule.
7. I will report issues and concerns in a timely fashion to my PSH Guest Access Sponsor or in their absence to the 24 hours IT Technical Support Center at 717-531-6281.
8. I understand that PSH maintains electronic access logs for company owned and managed electronic information systems and networks; and that representatives of PSH reserve the right to monitor and review these logs to safeguard the confidentiality, integrity and availability of mission critical systems.
9. I understand that my USERID and password are to be used solely by me in connection with my authorized access. I agree to choose a difficult to guess password. I understand that I am required to sign off from the computer when I have completed authorized access, or when I physically leave the workstation, and that any access under my USERID and password by another person is my responsibility.

My signature below represents my acceptance of the conditions of use outlined above.

Applicant's Signature: _____ Date: _____

PSH/COM Sponsor's Printed Name: _____ Extension: _____

PSH/COM Sponsor's Signature: _____ Date: _____

Note: *As the authorizing party for this applicant, and reflected by my signature above, I have verified that this applicant requires the requested system access/classification to perform daily business responsibilities. I also understand I will be responsible to notify Account Management immediately should the applicant no longer require IT access.*