Beth Israel Deaconess Medical Center

Request Form – ADULT CareVue Access

To be completed by user: Please Print

Last Name:_____**First Name**:_____**MI**_____

Department:Medicine_____**Location**:Dea 311**SSN** (last 4 digits)#: __ /__ /__ /__ **EMAIL**:_____

Position:medicine intern_____**Professional Title** (i.e. MD, RRT etc)___M.D._____

☐ Student, ☑ Resident, ☐ Travel RN/RRT please fill in **(Required): Start Date**06/23/10 **End Date**___/___/___at BIDMC.

Confidentiality of Patient Information and CareVue Access

I am aware of and agree to abide by the following Beth Israel Deaconess Medical Center policies regarding the confidentiality of patient information:

- The unauthorized possession, use, copying, or reading of hospital records, or the disclosure of information contained in such records is strictly forbidden.
- I agree to access data in CareVue only as required for performance of my job related activities. Activity under my user ID shall be my responsibility.
- I agree to protect the confidentiality of the data by:
  - Never sharing my password or my access
  - Never use another employee's Carevue access.
  - Always logging off when leaving a workstation
  - Never disclosing confidential information except when required for my job and when properly authorized.
- The confidential trust, which law and professional ethics have imposed upon the medical and nursing professions, are equally applicable to all other Beth Israel Deaconess Medical Center employees.

I understand that violations of the above BIDMC security policies are grounds for disciplinary action including immediate termination of employment.

My login ID and password is my signature in CareVue. Willful abuse or irregularity on my part with the above terms shall be subject to disciplinary action.

Signature: _____ **Date**: _____/_____/_____

(Section below Required) – To be completed by *your (direct specialty report)*:
Department Director or Chief , ICU Attending, Residency/Fellow Admin., or Manager

Level of Access needed for job: ☐ Document in Carevue ☑ View Information in CareVue

I authorize this level of access for the above-named person. I accept responsibility for notifying the CareVue Application Administrator when this person no longer needs this access or is on my staff.

Name (Print): Andrea Crawford_____ **Position:** intern coordinator **Ext:** 2-8266

Signature: _____ **Date:** 03/18/10

e-Mail completed form to I. S. Support Call Center
NEW FAX NUMBER - #617-754-8099