Garden City Hospital

Business Associate Direct Messaging Request Form

REQUIRED INFORMATION MARKED WITH AN ASTERIK (*)

* *

☐ New Request

☐ Change of Access

☐ Additional Access

A middle initial is required if employee has one

User Name * _____ * _____ * _____

Last First MI

Department Name * _____

Job Title/description * _____ User Phone/Ext * _____

Employment Status: * ☐ Business Associate Name: _____

By signing this document, I acknowledge that all information accessed or obtained from Prime Healthcare Garden City Hospital its affiliates is private and confidential, and will be used only for professional purposes. Any dissemination, distribution, or copying of this information is strictly prohibited. If I believe I have received any information in error, I will notify the Health Information Management department immediately. I will be responsible to ensure no one else is able to use my UserID and will not share my password. Your access may be revoked during an investigation of a breach of confidentiality or security. Failure to follow these principles will result in disciplinary action. I have read, accept, and acknowledge the above statements and will abide by security and confidentiality policies.

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

My signature below acknowledges that I will notify Garden City Hospital Health Information Management Department at (734) 458-4355 when the Business Associate is terminated so that access can be revoked.

* _____

Signature of Department Director / Physician Date

* _____

Signature of Department Director / Physician Date

INCOMPLETE DMRFs WILL NOT BE PROCESSED.

INFORMATION SYSTEMS ONLY

_____ _____ _____

Date Completed IT SIGNATURE User Profile Assigned

_____

Business Associate Contract Reviewed by Administration

Please mail completed DMRF to:

Garden City Hospital
Health Information Management
Attn: Nicole Newhouse
6245 Inkster Rd
Garden City, MI 48135

-OR-

Email to nnewhouse@primehealthcare.com