LCMC Health Link

Affiliate Provider Application

How to Get Access

1. The Site Administrator should download and complete this LCMC Health Link Affiliate Provider Application. This should be submitted for MD, NP, PA and DO provider types.

   NOTE: Before typing into this form, first download and save this PDF application to your computer. Your application will not be saved if you complete this application directly in your browser.

2. Once complete, Site Administrator should email application along with the completed User Access Request Form (Excel file) to link@lcmchealth.org

Once we receive the completed application and access has been approved:

1. The Site Administrator will receive their staff's LCMC Health Link log-in credentials. This email will come from an automated system.
2. Within 5 business days of the credentials being sent, the staff member will be able to log into LCMC Health Link.
3. Training information will be available to each staff member once they log into LCMC Health Link.

Thank you for your interest and cooperation. Once you submit your application, you will receive a confirmation of receipt.

Computer Account & Clinical Systems Application

(Authorizing Provider)

Last Name: _____ First Name: _____ Middle Initial: ____ Prefix: _____

Date of Birth: _____/_____/_____ Sex: _____ Last Four Digits of SSN: _____ Credentials (MD, etc.): _____

Organization Name: _____ Phone: _____

Job Title: _____ Have prior access to Epic Systems at LCMC or LSU: _____

Email: _____

Clinical Systems Access:

	LCMC Health Link **Authorizing Provider (MD, DO, PA, NP)** *NOTE: Authorizing Providers must also complete the Application for Utilization of Diagnostic/Consultant Services on Page 9*

By signing this application, I agree to the following:

- I am familiar with the HIPAA Privacy Rule and will use and access PHI only where such information is necessary for treatment, payment, and/or operations purposes and only that which is the minimum necessary for such purposes;
- I shall protect the privacy, confidentiality and security of the PHI accessed in the LCMC Health Link in accordance with federal and state privacy regulations.
- I shall not access, remove, copy, or release information from LCMC Health Link without proper authorization to do so.
- I understand that my activities and access to the LCMC Health Link may be monitored and audited.
- I understand my responsibility to promptly report to LCMC Health and my employer any inappropriate access, use or disclosure of PHI that I observe or of which I become aware
- I acknowledge that I am accountable for all activity attributable to my logon ID. I will not share my logon ID and I will guard my password.
- I will use my logon ID to perform authorized activities only (i.e., to carry out employment, contract, or school-related responsibilities).
- I understand that, upon termination of employment, non-renewal of contract, or loss of active student status, LCMC may delete my logon ID and my data.

Applicant Signature: _____ Application Date: _____

SIGNATURE OF AUTHORIZED AFFILIATE REPRESENTATIVE (Site Administrator/Office Manager):

Authorizing Signature: _____ Date: _____

APPLICATION FOR UTILIZATION OF DIAGNOSTIC/CONSULTANT SERVICES

Last Name:_____ **First Name:** _____ **Middle Initial:**_____ Prefix:_____

Organization Name: _____

LA. Medical License #:_____ **Exp Date:** _____

Medical Specialty: _____

NPI #: _____ **Fax Number #:** _____

Are you a Medicaid Community Care Provider? ☐ **Yes** ☐ **No**

When referring a Community Care Medicaid patient, you must provide Medicaid Authorization when requesting services.

FOR PHYSICIAN ASSISTANT AND NURSE PRACTITIONER ONLY:

NAME OF SPONSORING MD: _____ **Phone:** _____

Email: _____

Note: Sponsoring MD must have diagnostic/consultant privileges with an LCMC Health Facility

LCMC Health Link Access & Confidentiality Agreement (Employee)

I, the undersigned, understand that I am being granted access to LCMC Health Link maintained by Louisiana Children's Medical Center and its affiliates. LCMC Health Link is a secure website that provides real-time read-only access to patient information, including protected health information (PHI); thru this application, affiliates can access patient's clinical data and communicate with LCMC about a patient's care, refer patients within the LCMC network, and submit lab and radiology orders.

LCMC and its subsidiaries and affiliates including University Medical Center, Children's Hospital, Touro Infirmary, West Jefferson Medical Center, and New Orleans East Hospital (Collectively "LCMC Health") are authorizing my access to LCMC Health Link with the express understanding that I will access only the minimum necessary information and that my access to this system is a privilege that may be revoked at any time.

The access I have been granted is contingent on my, and my employer's (or school's as applicable), compliance with the terms and conditions outlined in this document. I, therefore, agree to the following:

1. I am familiar with the HIPAA Privacy Rule and will use and access PHI only where such information is necessary for treatment, payment, and/or operations purposes and only that which is the minimum necessary for such purposes;
2. I am requesting access to, and will only access information regarding patients with whom I, or my employer, has or had a treatment (physician/patient), payment (including administering a health plan), or a health care operations relationship, and the subject of the information requested pertains to that relationship;

3. I shall protect the privacy, confidentiality and security of the PHI accessed in the LCMC Health Link in accordance with federal and state privacy regulations.
4. I shall comply with the privacy, confidentiality and security policies of LCMC Health.
5. I shall comply with the privacy, confidentiality and security policies of my own employer or the training program with which I am affiliated.
6. I shall not in any way divulge, copy, release, sell, loan, alter or destroy any PHI except as properly authorized by the policies of LCMC Health.
7. I shall never access, remove, copy, or release confidential medical or non-medical information without proper authorization to do so. I shall not allow any person to examine or make copies of any patient reports, documents, or electronic records unless authorized to do so.
8. I shall not electronically transmit PHI in a manner that is not secure and compliant with LCMC Health policies pertaining to the transmission of such information.
9. I shall not misuse or negligently care for PHI. At all times during my employment/training I shall safeguard all PHI and shall not attempt to gain access to information for which I am not authorized. When my authorized uses or communications of PHI result in incidental disclosures, I shall use reasonable safeguards to minimize the degree of these incidental disclosures.
10. If my employment is terminated during the course of my access to the LCMC Health Link or my participation ceases in the school training program with which I am affiliated, I shall return all accumulated PHI to my employer/program lead.
11. I shall safeguard and shall not disclose my access codes, passwords or any other authorizations I may have that allow me access to LCMC Health Link.
12. I shall not use the access codes and passwords of another individual to access the LCMC Health Link.
13. When exposed to confidential information, including PHI, I am responsible for keeping that information confidential.
14. I will not leave my computer unattended if health information is displayed on the screen or another person could use that computer to access health information without the necessity of an access code or other security measure.
15. I shall not access my own medical information.
16. I shall not access medical information of patients for any purpose that is not related to treatment, payment, or healthcare operations.
17. I understand that my activities and access to the LCMC Health Link may be monitored and audited.
18. I acknowledge that my failure to comply with the foregoing representations and warranties, or any misuse of my login or credentials may result in termination of this Access Agreement, termination of my access to LCMC Health Link, as well as disciplinary actions imposed by my employer, which may include termination of employment, or by the school training program with which I am affiliated. I also acknowledge that I and/or my employer may be subject to civil or criminal penalties as described by federal/state law.
19. I understand my responsibility to promptly report to LCMC and my employer any inappropriate access, use or disclosure of PHI that I observe or of which I become aware.

ACKNOWLEDGEMENT:
My signature below signifies that I have read and agree to comply with the terms of this Access Agreement governing the use of LCMC Health Link and LCMC's electronic medical record. I understand that a violation of this agreement may result in sanctions, including but not limited to reporting the violation to the appropriate licensing agency or board, as well as civil or criminal liability.

_____ _____
Applicant Signature Date

_____ _____
Sponsoring Provider Signature (For NPs and PAs Only) Date