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: _____