3RD PARTY COMPUTER ACCESS REQUEST

REQUESTOR: **Complete and Fax** to VHS Information Services **(702) 853-8953**.
Please **PRINT** all information.

Requestor Last Name	First Name	Initial	Requestor Contact Phone #

**** You must enter either a FAX number or an Email in order to receive your login ID ****

Requestor Complete FAX #:	Requestor Email Address:

Name of Group/Company/Physician Practice:	Telephone #:	Purpose of Access Request: *(Please be detailed. In accordance with HIPAA Privacy Rule, access is granted on a Need-To-Know basis.)*
Office Supervisor Name:	**Telephone #:**	

**** To Be Completed by Provider/Case Management RN ****

State License #:	Specialty:

Select the Hospital Access Needed For:

❑Centennial | ❑Desert Springs | ❑Henderson | ❑ Summerlin | ❑ Spring Valley | ❑Valley

Select Appropriate Type of Access Needed:	Second Level Approval Signature (VHS I.S. to Obtain):
❑Physician ❑AHP ❑Medical Scribe ❑Student Medical	**N/A**
❑Government Agency ❑HIM Reviewer ❑Insurance ❑Medical/Legal (Attorney) ❑Physician Office Staff ❑Other: ____________________	**HIM Management:**
❑Case Manager ❑ Other: ____________________	**Case Management:**

How you will access the system:	Access START Date:	Access END Date:
❑Onsite (on site at the hospital) ❑Remote (off site from the hospital) ❑Both		

APPLICATIONS REQUESTED (Check All That Apply):

☒VHS Network Access (required for any access)

❑CERNER ❑Dragon Direct ❑Fetalink (OB Docs) ❑Fetalink+ (iPhone App)

❑Radiology PACS ❑Cardiology PACS ❑MUSE (For Cardiologists Only)

❑Other (Please Specify):____

Requestor Signature:		Date:	

Please select all applications required. Please submit the VHS Data Access Agreement Form along with this form.

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