The Valley Health System

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:	**Office Supervisor Telephone #:**

Office Supervisor Email Address:

**** 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	❑Valley Health Specialty Hospital

Select Appropriate Type of Access Needed:

❑Physician ❑AHP ❑Medical Scribe ❑Student Medical

❑Government Agency ❑HIM Reviewer ❑Insurance
❑Medical/Legal (Attorney) ❑Physician Office Staff
❑Other: _____

❑Case Manager ❑ Other: _____

Second Level Approval Signature (VHS I.S. to Obtain):

N/A

HIM Management:

Case Management:

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

Access START Date:

Access END Date:

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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