Yale New Haven Health System
RESEARCH REQUEST FOR MEDICAL RECORD ACCESS

REQUEST FOR ACCESS TO:

☐Epic Hyperspace ☐DataArk (SCM, Medipac, Quadramed) ☐ChartView ☐Centricity ☐PACS Synapse
☐Other _____

Section I – Approval to be Completed by Authorizing Primary Investigator (Required for form processing)
Please allow 5-7 business days for processing. ***If you have not received your access in that time frame, please contact the Helpdesk at (203) 688-4357.***

By signing this request, I assume responsibility for the access granted for the listed individual(s).

Authorizer's Name (print):	**Title:**
Signature:	**Date:**
Phone:	**Contact Hours:**
Email:	
Office Address:	

Reason for Request: _____

☐ **IRB Approval: IRB#:**_____ ***(Attach IRB approval)***

☐ **IRB Exemption: IRB#:**_____ **(*Attach IRB exemption determination*)**

☐ **IRB Review Not Required: (*Check the reason below and attach Confidentiality Agreement)***

☐ **Quality Improvement** ☐ **Research Limited To Deceased Individuals Only** ☐ **Activity Preparatory to Research**

Note: Studies involving both living and deceased individuals require IRB review

Duration of Requested Access _____/_____/_____to_____/_____/_____ (Limited to One Year)

Section II - All fields required for Individual needing access

User Name (print): (LAST) (FIRST) (MI)

Office Address:	
Office Phone & Pager: ( ) _____ - _____	**NPI# : (FOR LIP ONLY)**
Email Address:	**Position/Role Title: (RN, RRT, ETC.)**
Affiliation: ☐ YNHH ☐ YMG ☐ Yale University ☐ GH ☐ BH ☐ NEMG	**Clinic Area/Department:**
	☐ Employee ☐ Student ☐ Medical Staff Member Other: _____

Please attach list of medical records/service dates required for research study. If limited list cannot realistically be provided, please provide reason:

☐ **List Attached** ☐ **Access cannot be limited for the following reason:**

HIM Department Use Only:

HIM Staff Member's Full Name :_____
HIM AUTHORIZING SIGNATURE:_____ **DATE:** _____
TITLE: _____

Please send complete form by Fax or Email to:

Health Information Management Dept.
Fax Number: (203) 688-0289
Or Email to: EpicCare.eHIM@ynhh.org

YALE NEW HAVEN HEALTH SYSTEM
CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

I understand that as an employee, member of the medical staff, physician office employee, or non-YNHHS patient care provider or support personnel (volunteer, intern, student, contractor, vendor, etc.) of Bridgeport Hospital (BH), Greenwich Hospital (GH), Yale-New Haven Hospital (YNHH) or Yale New Haven Health System (YNHHS), the performance of my job may require me to access or become aware of confidential information, such as:

- Patient health care and financial information (otherwise known under HIPAA as Protected Health Information or PHI)
- Employee personnel, compensation and health care information
- Physician performance and personnel information
- Business information relating to BH, GH, YNHH, or YNHHS (including financial, administrative, resource management, and other information)

By signing below, I agree to the following:

a. I understand that approval to access and use this information in verbal, written, or electronic (stored in computer) form is a privilege. I also understand that access to hospital or YNHHS information is granted to me based only on business or clinical "need to know" standards and the responsibilities of my job as an employee, member of the medical staff, or nonYNHHS patient care provider or support personnel. I agree to access information only on patients for whom I, my office, area, or department has responsibility. Patient information may be used for research or teaching purposes only when authorized by the appropriate institutional review board and in compliance with hospital or YNHHS Policies and Procedures.

b. I understand that the methods I use to get information may only be used in the performance of my job. I understand that if granted a sign-on code, password, and/or "physical token device" that I accept full responsibility for any use or actions taken with my sign-on code(s), password(s) (codes), physical token device or Personal Identification Numbers (PIN), and recognize that, in some cases, these codes are the equivalent of my signature. The codes will be used only by me and I will not use another person's codes at any time. I will notify the IS "Help Desk" immediately should my code(s) be compromised in any way, or if my token is lost or stolen. I will reimburse the hospital/YNHHS for the cost of the token, if not recovered. **Violation of this Agreement** will result in **For Physicians:** disciplinary action up to and including dismissal from the Medical Staff and/or House Staff of a member Hospital; **For Employees:** disciplinary actions under the guidelines of the hospital/YNHHS Resources Policies and Procedures; **For Non-Employees:** disciplinary actions up to and including immediate termination of your relationship with the relevant hospital. In addition, **violation of this Agreement** may result in possible legal action, or fines against you and the organization you represent.

c. I understand that I may not seek access to any information that is not required to do my job. I understand that an audit trail, noting my code(s) or PINs, the patient, or system accessed and the date may be reviewed by the hospital or YNHHS. I understand that patient information accessed through the computer is considered the same as the patient's medical record and may not under any circumstances be re-disclosed without proper authorization as covered in the YNHHS and/or Hospital By-Laws and Policies and Procedures. I agree to access, use, store and dispose of information which I use in a way that ensures continued security and confidentiality in accordance with hospital/YNHHS Policies and Procedures.

d. I understand that computer hardware, software, and information are considered hospital or YNHHS property and are subject to and protected by appropriate hospital/YNHHS Policies and Procedures.

e. I understand that the hospital/YNHHS reserves the right to make modifications to its access program including revoking codes and requesting the return of any token access devices.

f. I understand my access privileges will be revoked if any of the above understandings are violated.

Signature:		**Date:**
Print Name:	**Title:**	
Affiliation: **(YNHH, BH, GH, HSC or Affiliate, Yale University, Community, Company, Other)**	**Dept:** **(Dept, service)**	**MSO#:** **(If applicable)**
Hospital Privacy Representative/HIPAA Training Coordinator:		**Date:**