QUALITY HEALTH® N·E·T·W·O·R·K

Improving care through shared technology

QualityHealthNetwork.org

New User Packet

Quality Health Network's (QHN) health information exchange (HIE) provides you instant access to patient information to improve patient care and care coordination.

Both the ***User Profile Form*** and ***New User Form*** included in this electronic packet are required for each User requesting access to the QHN system.

To complete the process of establishing a User request in a timely manner, please ensure we have accurate and legible information by typing the information into the designated fields on the forms.

Once the forms are completed, they may be electronically signed and emailed to: **Support@qualityhealthnetwork.org,** or printed, signed and faxed to QHN at: 970.248.0043.

Double click on the forms and save a copy to your computer prior to entering any information.

- ***User Profile Form*** – To be completed by the designated organizational contact. Contact should fill-in all designated fields, acquire appropriate signatures and date.
- ***New User Form*** – To be completed by the individual requesting access to the QHN system. The User is required to complete all designated fields, initial, sign, and date the form.

The QHN Clinical Account Managers and Customer Support team are here to assist you in acquiring access to the QHN system. They may be reached at 970.248.0033, or at the email addresses noted below.

QHN Customer Support: support@qualityhealthnetwork.org

Sherri Corey: scorey@qualityhealthnetwork.org

Annie Schudy: aschudy@qualityhealthnetwork.org

Cherie Schmitz, *Clinical Admin. Assistant:* cschmitz@qualityhealthnetwork.org

QHN office hours: M - F, 7:30 a.m. - 5 p.m.

Fax number: 970.248.0043

User Profile Form

To be completed by designated Organizational Contact

Please complete the Practice/Organization information below. The **User Profile Form** is used to delineate the type of access requested for the below noted User and must be completed for each User. **All Patient Summary access shall be limited to Users who have been authorized to have access to the QHN System and are: (1)Licensed (without restriction) healthcare providers or are supervised by a licensed healthcare provider, and (2) have a job that involves direct patient care or direct support to patient care that requires Patient Summary access.** User will be notified with their secured access information by phone. Completed form may be electronically signed and emailed to: Support@qualityhealthnetwork.org or printed, signed and faxed to QHN at: 970.248.0043.

Practice | Organization | Facility Information

Practice | Organization | Facility Name: **Department:**

User Information

Full Name: *First* *Last* *M.I.* **Specialty:**

Email address: **Professional Suffix / Title:**
Select from dropdown menu, if applicable

NPI #: **License #:**

If User will access QHN using Single Sign On (SSO) please note their user name (for your EHR system) below:

Will training by a QHN representative be requested? Note: fee may apply. Yes: ☐ No: ☐

User Access Requested

- **Demographics:** User needs access to view Patient Demographics only. ☐

All below requested access includes Demographics

- **Organization Results:** User needs access to results associated with all the providers within the practice. ☐
- **Patient Summary**: User needs access to the patient results from all QHN sources (Patient Summary). ☐
  One time processing fee may apply ($50). I understand this will be added to our organizations monthly invoice.
- **QHN Direct**: User needs a secure Direct Email account (please review the Tip Sheet on **Designating Direct Delegates**). ☐
- **Other**:

Signature

By signing below, I certify that User has completed the required **HIPAA and Confidentiality** training and all information contained herein is accurate. I affirm that my organization's access and use of the QHN system(s) shall be in compliance with the Electronic Commerce Agreement between my organization and QHN, applicable law and QHN's policies and procedures and that any inappropriate use or access to the QHN system may result in the imposition of sanctions by QHN, against me and/or my organization that could include loss of use of the QHN System, notice to licensing authorities, and/or civil or criminal penalties. I have certified the identity of the individual noted above by viewing and verifying two legal forms of identification.

Designated Organization Contact Signature (required) | Printed Name | Email address | Date

744 Horizon Court, Suite 210 Grand Junction, CO 81506 • Phone: 970-248-0033 • Fax: 970-248-0043

New User Form

To be completed by User requesting QHN access

The information below is required to be completed by each User requesting access to the Quality Health Network (QHN) System. Users will be notified by phone, with their secured access information when their account has been established in the QHN System. Once the form is completed by typing into the below fields, it may be electronically signed and emailed to: Support@qualityhealthnetwork.org or printed, signed and faxed to QHN at: 970.248.0043.

User Information

Full Name: *First* *Last* *M.I.* **Date:**

Professional Suffix: Select from dropdown menu, if applicable **Other Title:**

Preferred Contact Phone: **Cell Phone:**

Preferred Contact Email Address:*

**Please note: This email address is used for the reset password function in the QHN system.*

Please list the work location(s) where you will access the QHN system below:

Security Information (Used to verify your identify for Password changes, etc.)

Last 4 Digits of Your Social Security Number: ☐☐☐☐

Month and Day of Birth: **Month:** ☐☐ **Day:** ☐☐

User Acknowledgement and Signature

It is your responsibility as a User of the QHN System to ensure your password is kept confidential. Please **INITIAL** next to each statement and sign at the bottom.

☐ I will change my password and set my security questions during the initial login process to the QHN System. In so doing, I understand that no one else, including Quality Health Network, will know my password or my responses to my security questions.

☐ I will not share my password with anyone or ask another user for their password.

☐ I will not log anyone else on to the QHN System using my password.

☐ I understand that upon accessing the QHN System for the first time, I will be asked to accept additional policies above and beyond those outlined in this document.

☐ I understand that any inappropriate access to the QHN System may result in the imposition of sanctions against me, my supervisors and/or my organization that could include loss of use of the QHN System, notice to licensing authorities, and/or civil or criminal penalties.

☐ I understand and agree to be bound by all the above statements.

Signature: _____ **Date:** _____

Printed Name: _____

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