Change Request Form

User Name or Access Change | Delete User

Please provide the information below for the individual whose QHN User account requires a change or is to be deleted. Please check the appropriate reason for change: ***Name Change, Access Change or Delete User*** and complete the required fields. **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:

NAME CHANGE: Change User name FROM: TO:

Name change results in address book no longer accepting the previous name. User will need to be located under new name.

ACCESS CHANGE: Complete QHN User information below

Full Name:

First *Last* *M.I.*

Email address (required for QHN Direct secure email):

User Access Change 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**).
- **Source Clinical**: User needs access to view Hospital results only (for hospital employees).
- **Other:**

DELETE USER: Name of User to be deleted: Date to delete User:

If deleted User is a provider, please note if their results are to be routed to current practice location for two weeks. Yes No

Signatures

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

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