CROUSE HEALTH
Request Form for Care*Xpress/Soarian*

SECTION 1: To Be Completed by Customer (*One Form Per User)* - USER INFORMATION

Name: ________________________________ **Practice** Name: ________________________________
(Please **PRINT all** information)
Practice Address: ____

City/State/Zip: ____________________________ Phone #: (_____) _____-______ Fax #: (_____) _______-______

Date of Birth: _______-______-______(**REQUIRED**)

Office Manager Name: ________________________ **REQUIRED Email Address**: ________________________________
(***This address will be used to send official communications***)

Company Used for IT Support/Contact Name & Phone: ____________________________ Phone #: (____) ______-______

All activity on your user ID and password is your responsibility. User ID's and passwords will be transmitted via email to the email address given above. As a security measure, they will NOT be given out over the phone for any reason. **When an employee no longer requires access to the system, Crouse Information Technology <u>must</u> be notified immediately by the Office Manager. Please see Section 2 below.**

<u>Select Type of User</u>: ☐ Physician ☐ PA ☐ NP ☐ Nurse ☐ Office Staff ☐ Billing
☐ Vendor ________________Other ________________________________

Did you previously have access to Crouse Health from a different office? ☐ Yes ☐ No Office name________________

Confidentiality Statement and Terms of Use
Data stored at and transmitted by this website contains PHI (Protected Health Information as defined by HIPAA Privacy regulations). By using this website you agree to access, use and disclose information, including PHI, in compliance with applicable federal and state privacy and security standards. Crouse Health has taken steps to ensure data confidentiality and integrity at the server and during transmission over the internet. Crouse Health has provided you with credentials for accessing this website. These access credentials are for your official use only and may not be shared with others. You shall immediately report any unauthorized use of your access credentials to the HIPAA Privacy or Security Officers. You shall take reasonable and appropriate workstation security measures and shall not leave your computer unattended while logged on to the website. Website access and activity is monitored and logged. You are responsible for all activity performed using your access credentials, including not accessing your own personal PHI without proper authorization. Your confidentiality obligations set forth herein shall survive termination of your access credentials for any reason.

User Signature: ____ Date: ________________

User **<u>Printed</u>** Name: ____ **Title**: ________________

Authorized Signature: ____ Date: ________________
Office Manager

*****SECTION 2: To Be Completed by Customer – USER TERMINATION or REVISED ACCESS*****

Please complete this section and return this form if the User no longer requires access to Crouse CareXpress due to termination. If the User requires revised access due to a change in job status, please note that change below.

<u>Select Type of Change</u>: **User Name**: ____

Termination: **Effective Date**: _____________ ☐Revised Access: **Effective Date**: _____________
<u>Select Type of User</u>: ☐ Physician ☐ PA ☐ NP ☐ Nurse ☐ Office Staff ☐ Billing ☐ Other______________

Authorized Signature: ____ Date: ________________
Office Manager

Please return this signed authorization form via fax at (315) 470-1395, ATTENTION: PATTY CASTER or you may PDF the completed form to: CX2Support@crouse.org