



# St. Luke's

**Remote Access Request Form  
Application Website**

The purpose of this form is to request access to St. Luke's application website.

Please fill out this form completely and fax to Network Security Analyst @ 218.249.5588

Once your remote access request is approved, a security device (token) will be mailed to you along with instructions. Please allow 10 days for your request to be processed.

By signing this form, the user agrees to the following:

- The token PIN number will be kept confidential
- Loss of a token will be reported immediately to the St. Luke's Helpdesk @ 218.249.2447
- Upon termination of employment, the token will be returned to the St. Luke's Helpdesk

Preferred method of contact:  Email  Phone

\_\_\_\_\_  
Employee Name (First, MI, Last) (Please Print)

\_\_\_\_\_  
Facility/Department

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Manager Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

Reason for remote access \_\_\_\_\_

**St. Luke's Use Only** (Do not write below this line)

\_\_\_\_\_  
User ID

\_\_\_\_\_  
IT Director Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
VP Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Records Director Signature

\_\_\_\_\_  
Date

Employment Verified  Request Approved  Request Denied Reason \_\_\_\_\_



## ACKNOWLEDGEMENT OF CONFIDENTIALITY

St. Luke's Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. I understand that in the performance of my duties as an employee/physician/volunteer/student/consultant/other of St. Luke's, I may have access to confidential patient information even though I may not be directly involved in providing patient services. I understand that such patient information must be maintained in the strictest confidence.

I understand and agree that, unless directed by my supervisor, **I will not** at any time during or after my employment/assignment with St. Luke's:

- Disclose any confidential patient information to any person whatsoever
- Permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control
- Use patient information, other than as necessary in the course of my employment/assignment
- Disclose proprietary information including business practices, quality improvement or statistical information
- Access the medical records of my family, including my parents, spouse or adult children
- Access my own medical record or the medical record of my dependent children without contacting the Medical Record Department and following proper procedures

I understand access to printed or electronic patient information must, at all times, be related to the performance of my job.

When patient information must be discussed with other healthcare practitioners in the course of my work, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear these conversations.

I understand it is my responsibility to hold in confidence my computer access password, and to notify Information Technology immediately if I feel security of my password has been compromised in any way.

Any violation of patient confidentiality will result in disciplinary action up to and including termination.

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(SIGNATURE)

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(DATE)

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(PRINTED NAME)

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(DEPARTMENT)