Client Access to NorDx Information Systems Request/Termination Form-NorDxNow

CLIENT INFORMATION (PLEASE PRINT)

- **ACCESS** REQUEST FOR NORDX SYSTEM: ☐ NorDxNow ☐ New Account ☐ Change Request MAINEHEALTH ENTITY ☐ Y* ☐ N
- **TERMINATION** REQUEST FOR NORDX SYSTEM: ☐ NorDxNow *Enter an Account Request to create a Footprint

CLIENT NAME _____ CLIENT ID _____ PROPOSED GO LIVE DATE _____

GROUP CONTACT _____ TITLE _____

ADDRESS _____ PHONE _____

_____ FAX _____ EMAIL _____

PRACTICE ADMINISTRATOR

NAME (Last) _____ (First) _____ (M) ____

EMAIL _____ Title _____

NorDxNow USER INFORMATION

Last Name	First Name	Middle Initial	MaineHealth Network ID*	Job Title	Work Email Address	Access Requested (Minimum Need)	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	

Last Name	First Name	Middle Initial	MaineHealth Network ID*	Job Title	Work Email Address	Access Requested (Minimum Need)	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	
						Select Access	

NorDx Information System Use Agreement

The following agreement will fulfill the security and privacy of Protected Health Information as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My signature represents that this practice as a client of NorDx will adhere to the statements below:

- Access to the NorDxNow Laboratory Information System for the entry of laboratory testing orders and/or the retrieval of laboratory results for patients of the above listed client is provided by NorDx for patient treatment purposes.
- The Client/practice is responsible for adopting and implementing appropriate policies, procedures and safeguards so that access, use and disclosure of information made available through the NorDx Information System(s) complies with HIPAA regulations and other applicable federal and state law.
- I have verified the accuracy of the user names and access levels listed on this form.
- An Individual system user name and a password will be provided to each person designated. It is the responsibility of the Client that passwords remain confidential to the user **and to notify NorDx when a user terminates employment**.
- In the case of a breach of protected health information by any user above, with a NorDx system or derived from a NorDx system you must **notify NorDx of the breach within 5 business days and provide proof of notification to the applicable patient and user sanctions applied**.
- In these instances, the practice will be responsible for any reporting obligations according to HIPAA regulations.

PRACTICE ADMINISTRATOR

My signature below represents that this practice as a client of NorDx will adhere to the statements above:

PRINT Name _____ Title: _____

Signature _____ Date: _____

NorDx Account Manager

PRINT Name _____

Signature _____ Date: _____