

Physician Connect Access Request

Please grant Physician Connect access to those listed below. I understand that all Physician Connect access is subject to **monitoring and review** by The Doctors Clinic and/or designated representatives for regulatory compliance. I acknowledge that the patient data accessed via Physician Connect is to be used solely for **treatment** of a particular patient. It is my responsibility to use Physician Connect in accordance with the Access Agreement and Appendix C I have signed with The Doctors Clinic granting me access. I recognize that it is my responsibility to contact The Doctors Clinic when a user has left the employ of our office. I understand any misuse or violation of Physician Connect Policy & Procedure will result in the loss of access for my designated staff and me.

Physician Name/Entity: _____ Signature: _____ Date: _____

Physician signature is required for staff members within the physician practice

Please print legibly first and last names of all users needing access	Add \ Delete / Change	Physician or Staff	Last 4 of Soc Security (for password verification)		
	A/D/C	P/S	####	Employee's Title	Email Address
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Practice

Name: _____ Office Phone: _____ Office Fax: _____

Address: _____ Contact person/ Mgr: _____ Email: _____

_____ Phone: _____