

**CHLA WebConnect Request Form**

This form is used to request a CHLA WebConnect account from CHLA Information Services. Please follow all the instructions below.

Step 1: Completely fill in the information for Sections 1 & 2.

Step 2: Read and sign the Confidentiality of Information Policy in Section 3. Step 3: Have your Director sign the approval.

Step 4: Forward this form to the IS Service Desk (x14444, MS# 39) for further processing

**SECTION 1: PERSONAL INFORMATION**

Name: (Last) (First) (Middle)

Department: Extension: Date:

Director: Extension:

Network ID (name you login with):

Are you a CHLA Employee? circle: (**YES** / **NO**) If **NO**, fill in below:

Who is your employer? Who is your CHLA sponsor?

**SECTION 2: SECURITY QUESTIONS**

What is the compelling business reason for you to use CHLA WebConnect?

How long is this access required?

How frequently will this be used?

Where is this going to be used from?

Will PHI (Protected Health Information) be accessed? circle: (**YES** / **NO**) What devices, services or applications will be accessed?

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**SECTION 3: CONFIDENTIALITY AGREEMENT AND APPROVALS**

**CONFIDENTIALITY OF INFORMATION POLICY**

In order to protect the confidentiality of patient care and hospital matters, Children’s Hospital Los Angeles considers all information regarding its patients, their families, hospital employees and hospital business as confidential. All personnel using Children’s Hospital Los Angeles Remote Access Services are required to adhere to this policy and not relate or disclose any information without appropriate written authorization. This policy includes the confidentiality of medical staff records and procedures, all patient information, employee personnel files, and information contained in the hospital computer systems. The hospital complies with all applicable federal and state laws regarding the release of information.

ACKNOWLEDGEMENT

I (print name) , have read and agree to comply with the above policy governing confidentiality of information at Children’s Hospital Los Angeles. I understand that I am prohibited from divulging any information regarding patients, their families, employees, or matters related to hospital business except as mandated by law.

Requester’s Signature

**For Non-employees’ account: Sponsor agrees to accept all disciplinary action resulting from any security violations associated with the above-referenced account.**

My signature below denotes approval for the use of by this requester:

Director Print Name Date Approved

Information Security Manager Print Name Date Approved

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