* **Submit this form to your Local WITS Staff Administrator or I.T. Coordinator**
* **TYPE** your information in all fields**, PRINT, SIGN HANDWRITTEN, incomplete, or out of date forms will not be accepted.** 
  + **An active Windows Active Directory account is necessary for WITS Accounts to be created. Non-DMHAS Agencies (PNP’s) must provide a staff person or Agency email contact with all User Access Requests.**

**User Information**

|  |  |  |
| --- | --- | --- |
| **Date:** | | **Employee Id:** |
| **Name First MI Last**: | | |
| **Facility:** | **Site/Unit:** | |
| **Phone #: ()   -     Ext:** | **AD Username:       & E-Mail:** | |
| **Professional Credentials:** | **Clinical Supervisor’s Name:** | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Access Request:** | New | Additional | Replace | Deactivate |

**Facility Access :** (users who require access to multiple Agencies need separate access request for each if access rights are different)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CMHC | CRMHC | RVS | SMHA | SWCMHS |
| CVH (including Blue Hills) | | |  | |
| WCMHN | DMHAS - OOC | DMHAS - OFE | WFH |  |

**WITS Application :** (check all User Roles that apply)

|  |  |
| --- | --- |
| **Clinical Staff** - Psychologists, LCSW , MHA, PT/OT, Nutritionist, Rehab Therapist, Recovery Support Specialist (Includes Crisis & Homeless Outreach) | **Prescriber** - Psychiatrist, Internist MD, Physician’s Assistant, APRN, Resident Student (as appropriate) |
| **Crisis \*** WillAdd Crisis Reports access with this Role |
| **Nurse** - RN, LPN | **Jail Divervsion** |
| **Data Entry** | **OFE** |
| **Receptionist** | **QA/Billing** |
| **Intake** (OP) | **Clinical Supervisor** |
| **UM Screening** (IP) | **Manager** |
| **Admissions** (IP) | **Staff Account Creation/Edit** |
| **HIM/Medical Records** | **Password Reset** |
| **HIM Release of Info Module** |  |
| Other: | |

**Reports:** (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Viewer | Agency User | Cross-Agency Viewer | Cross-Agency User |
| “Viewer” permits read-only access to reports. “User” permits reading and creating new reports. “Cross-Agency” permits use of all DMHAS data | | | |

|  |
| --- |
| Notes: |

**For DMHAS Use only**

|  |  |  |
| --- | --- | --- |
| Account Created by Sign off by: | Initials: | Date: |

**Confidentiality Pledge**

|  |  |
| --- | --- |
| Name**:** | Date: |
| Facility: | DMHAS Site: |

**I** of  , pledge that any Department of Mental Health and Addiction Services “Confidential or Restricted State Data” or ”Protected Health Information” to which I have access through a Clinical Information System and / or any other information I may gain access to as a result of the granting of this request will be shared only with appropriate, authorized personnel, will not be stored on any mobile computing device, including but not limited to, portable devices such as laptops, thumb drives , flash drives, PDAs, portable memory devices, Blackberries or any other type of electronic storage or storage media equipment without proper authorization forms signed by the DMHAS Commissioner or her Designee. I will adhere to the State of Connecticut “Acceptable Use of State Systems Policy” that includes but is not limited to, “Connecting personally owned hardware” to the network or computing devices. I will adhere to the DMHAS OOC Policies and Procedures. I further pledge that I will not reveal my passwords, security IDs/codes/keys or like information to any other person. I will adhere to the Commissioner’s Policy Statement; Subject: Computer Use Policy; Chapter 7.2, Dated October 12, 2012, and all subsequent revisions.

I understand that Laws pertaining to confidentiality of patient/client records also apply to information stored electronically and I understand that violation of patient/client confidentiality is potential grounds for civil suit and substantial fines. Additionally, I understand that violation of this pledge may be grounds for disciplinary action, potentially including termination of employment.

I agree to complete the DMHAS administered Corporate Compliance and Ethics Training.

**My signature confirms that I have received, agree to, and will adhere to policies as detailed above.**

|  |  |
| --- | --- |
| Signature of Requester: | |
| Typed Name: | Date: |

|  |  |
| --- | --- |
| Signature of Requester’s Supervisor : | |
| Typed Name: | Date: |

Confidential or Restricted State Data includes but is not limited to:

* 1. Personally identifiable information that is not in the public domain and if improperly disclosed could be used to steal an individual’s identity, violate the individual’s right to privacy or otherwise harm the individual.
  2. Organizational information that is not in the public domain and if improperly disclosed might cause a significant or severe degradation in mission capability, result in significant or major damage to organizational assets, result in significant or major financial loss, or result in significant, severe or catastrophic harm to individuals.

Protected Health Information (PHI) data includes but is not limited to

* 1. Health information that could reveal the identity of a person.
  2. Under HIPAA, PHI identifiers include Name, Street Address, City, County, Precinct, Zip Code, Dates (except year) that directly relate to a person including, Social Security Number, birth date, admission date, medical record number, health plan beneficiary number, discharge date, and date of death.
  3. Telephone numbers, Fax numbers, E-mail addresses, Account number, Certificate/License Number, Vehicle Identifiers and Serial Numbers including License Plate Numbers, Device Identifiers and Web Universal Resource Locator (URL) , Internet Protocol (IP) Address Number, Biometric Identifiers (for example, finger or voice prints), full face photographs or similar images and any unique identifying number, characteristic or code.

State of Connecticut Acceptable Use of State Systems Policy includes, but is not limited to “examples of Unacceptable Use of State Systems” which prohibits connecting personally owned hardware http://www.ct.gov/best/cwp/view.asp?a=1245&Q=314686

Commissioner’s Policy Statement; Subject: Computer Use Policy; Chapter 7.2, Dated October 12, 2012 http://ct.gov/dmhas/cwp/view.asp?a=2913&q=460024



**CERTIFICATION**

**ELECTRONIC HEALT RECORD**

**ELECTRONIC SIGNATURE USER AGREEMENT**

I understand that when information is entered under my user identity, and the “sign” button is pressed, the entered information will bear my electronic signature.

By signing below, I certify that I will not under any circumstances release my user identification code or password to anyone, or allow anyone to access or alter information under my identity.

Further, I certify that my electronic signature is intended to be my legally binding equivalent of my traditional handwritten signature.

|  |  |  |
| --- | --- | --- |
| Name (Print): |  |  |

|  |  |
| --- | --- |
| Signature: |  |

|  |  |
| --- | --- |
| Date: |  |

*Original signed certification to be retained in the employee’s Personnel File*

*Copy to Health Information Management*

*Fax copy to EHR Project Team (959-200-4743)*

***Phone: (860) 418-7100***

***410 Capital Avenue, P.O. Box 341431, Harford, Connecticut 06134***

[www.dmhas.state.ct.us](http://www.dmhas.state.ct.us)

***An Equal Opportunity Employer***