Dear Provider;

Thank you for your interest in “View Only” access of Deborah Heart and Lung Center’s Electronic Medical Record system. Please fill out the entirety of this packet.

Please allow up to five (5) business days for a request to be processed.
Once approved, login information will be emailed to the provider.

Send completed documents to:

DVRequest@deborah.org

DEBORAH VIEW REQUEST FORM
PLEASE ANSWER ALL QUESTIONS

NAME:_____ SPECIALTY:_____

Suffix (select one): ☐ MD ☐ DO ☐ APN ☐ PA ☐ Other (specify): _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Cell Number: _____ Email Address: _____

Current Practice Name: _____ Position : _____

Current Practice Address: _____
(Street) (City) (State) (Zip Code)

Office Phone Number: _____ Office Fax Number: _____

NPI #:_____ US Citizen: ☐ Yes ☐ No Visa # (if applicable): _____

List all current medical licenses:

*Medical License:*_____ *Medical License:*_____
State and # *State and #*

*Medical License:*_____ *Medical License:*_____
State and # *State and #*

PACS ACCESS REQUESTS ONLY: ☐ *Individual Ordered Studies* ☐ *Group Ordered Studies*

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FOR ADMINISTRATIVE USE ONLY

Internal Use Only	***Space below for Medical Affairs ONLY***
Date Request received	
Clinical Licenses Verified	
SARF created	
Access granted	
Responsible Employee Name:	
Employee email or ext:	

AUTHORIZATION AND RELEASE

I acknowledge that I have expressed an interest in obtaining access to view the electronic medical record system at Deborah Heart and Lung Center (Center). I authorize the Center and Medical Staff representatives to query and inspect the applicable verification sources to include, but not limited to, the New Jersey Department of Consumer Affairs, State Medical Boards, Office of Inspector General and National Provider Identification Registry. I hereby release from liability all representatives of the hospital and its Medical Staff for their acts performed in connection with evaluating my background, credentials and qualifications.

I acknowledge all information so gathered will be maintained by the Center as confidential and not released without permission, except as may be required by order of a court or regulatory authority.

I hereby release from any and all liability, extend absolute immunity to, and agree not to sue, the Deborah Heart and Lung Center and its representatives for their actions in connection with evaluating the information provided on this questionnaire and determining whether I am eligible to receive an application. I understand that a determination that I am not eligible to receive access does not give rise to any hearing rights under the Medical Staff Bylaws.

I understand that I have the burden of providing all information deemed adequate by the Deborah Heart and Lung Center for a proper evaluation.

Accounts will be deactivated if there is no activity for 6 months.

Provider Signature: _____ **Date:** _____