OTHER FACILITIES ACCESS REQUEST TO ANTHC COMPUTER SYSTEMS

ANTHC Health Information & Technology, Service Center

Fax: (907) 729-8799 / **Phone:** (907) 729-2626 / **E-mail:** helpdesk@anthc.org

(Please TYPE or PRINT CLEARLY)

Important FAQ's to know:

For Users: If you already have access to ANTHC Computer Systems and need a password reset, you will need to contact the ANTHC Service Center at the above phone number.

For Supervisors: When an employee of your organization no longer is employed, please notify ANTHC Service Center and request for a deactivation of their access.

ACCESS INFORMATION –

☐ **REQUESTING ACCESS**

☐ **ANMC Provider Portal**

☐ **REACH**

☐ **Other:** _____

_____

☐ **DEACTIVATE ACCESS**

End Date: _____

End Date: _____

End Date: _____

End Date: _____

☐ **NAME CHANGE**

Previous Name:

_____

Access for Purpose of Research or Preparatory to Research: ☐ **Yes** ☐ **No**
If Yes, please write in AK IRB Protocol #_____. Or attach Privacy Consult.

USER INFORMATION – All Information Required and filled in by USER.

User Status: ☐ **Full Time** ☐ **Temporary:** **Temp Begin:** _____ **Temp End:** _____

Legal Last Name: _____ **Legal First Name:** _____ **M. I. :** _____

Job Title: _____ **Organization & Location:** (ie: BBAHC, YKHC, etc.) _____

Organization – E-mail Address: _____ **Work Phone:** _____

City of Birth: _____ **Date of Birth:** _____ (User: Please create a 4-digit personal identification number.) **4-Digit PIN Number:** _____

MD'S & MID-LEVEL PROVIDER INFORMATION – REQUIRED. A Mid-level provider is: ANP, FNP, NP, PA, CNM.

AK License #: _____ **NPI #:** _____

**********USER– PLEASE READ and SIGN**********

I have been instructed and fully understand that the information stored and processed on ANTHC computers and computer systems includes confidential patient medical data and other confidential patient and employee data governed by the Privacy Act. I hereby assume responsibility for the proper and confidential use of ANTHC computers and computer systems and agree to abide by all the applicable provisions of that Privacy Act.

I have been instructed and fully understand that the access and verify codes given to me are for the purpose of granting me access to the computer system. **The codes are for my use only and must be kept secret. Neither the codes nor the access granted is to be shared with anyone else.**

_____ _____

User Signature / Date: *User Name Printed*

_____ _____

Organization's Clinical Director's Signature & Date *Organization's Clinical Director's Name (Printed)*

_____ _____

Organization's Clinical Director's Phone / Fax *Organization's Clinical Director's E-mail address*