SACVALLEY MEDSHARE

SVMS Update Portal User Request

An SVMS **Update Portal User Request** should be completed for each User who needs their access to the portal updated. User will receive their secured access information by phone or encrypted electronic mail. This completed form must be electronically mailed to support@sacvalleyms.org. Fields outlined in red are required. If the user needs access to CURES; their first and last name, DEA and NPI must be on this form and must match their CURES database registration information.

To be Completed by Authorized Organization's Point of Contact

Practice/Organization/Facility Information

Practice/Organization/Facility: **Department:**

User Information

Full Name: *Last Name* *First Name* *M.I.* **Specialty:**

eMail Address: **Professional Suffix/Title:**

NPI #: *If applicable* **License #:** *If applicable* **DEA #:** *If applicable*

User Access Requested (must choose at least one)

- User Acceptance Testing (UAT) Full Access * ☐
- User Acceptance Testing (UAT) Regular Access ☐
- Production System (PROD) Full Access * ☐
- Production System (PROD) Regular Access *(Any user who does not need access to sensitive data)* ☐
- Direct Messaging Address *(Any user)* ☐
- Direct Messaging Administration/ Vault Administration ☐
- HIM ☐
- CURES *(Medical Staff that prescribes controlled substances)* ☐
- Other: ☐

** includes access to Substance Use Disorder and Behavioral Health Data*

Organizational Contact Signature

By signing below, I certify that User has completed the required **HIPAA and Confidentiality** training and all information contained herein is accurate. I affirm that all aces, by my organization, to the SVMS system(s) shall be in compliance with the Participation Agreement between our organization and SVMS, applicable law, SVMS governing policies and that any inappropriate use or access to the SVMS system(s) may result in the imposition of sanctions by SVMS, against me and/or my organization that could include loss of use of the SVMS system(s), notice to licensing authorities, and/or civil or criminal penalties. I have certified the identity of the individual.

- Type your full name, email address, and the date prior to signing as once signed, the form fields lock.

Submit to SVMS

Date *Full Name* *eMail Address* *Point of Contact Signature (required)*

To be Completed by SacValley MedShare

User Information

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

Username: _____ **Temporary Password:** _____

Direct Message Address: _____

User Access Setup Completed

- User Acceptance Testing (UAT) Full Access * ☐
- User Acceptance Testing (UAT) Regular Access ☐
- Production System (PROD) Full Access * ☐
- Production System (PROD) Regular Access ☐
- Direct Messaging Address ☐
- Direct Messaging Administration/ Vault Administration ☐
- HIM ☐
- CURES ☐
- Other: _____ ☐

** includes access to Substance Use Disorder and Behavioral Health Data*

SVMS Agent Signature

Date	*Full Name*	*SVMS Agent Signature (required)*