UNIVERSITY of MARYLAND MEDICAL SYSTEM

PortfolioMD Account Request

REQUESTOR INFORMATION (Please Type!)

** DENOTES REQUIRED FIELD

**LAST NAME		**PHYSICIAN NAME	
**FIRST NAME		**Contract End Date	
**MIDDLE INITIAL		(internal use only)	
**SSN (LAST 4 #S)		**PRACTICE NAME	
**DOB (MM/DD)		**PRACTICE ADDRESS	
**EMAIL ADDRESS			
FAX #		Specialty	

**PHYSICIAN LIASION:		**FACILITY:				** USER ROLE:	
		UMMC	☐	UMMidtown	☐	Clinical Support	☐
**Name	Judy A. Thomas	BWMC	☐	UMRehab	☐	Physician	☐
**Phone	410-822-1000 ext 5073	CRMC	☐	UMShore	☒	Site Administrator	☐
		SJMC	☐				

If this form does not include all required fields, this request will not be processed.

University of Maryland Medical System
Confidentiality of Information Statement

By signing this request, I acknowledge any access granted to the requested information system is to assist me in the performance of my professional responsibilities. I also acknowledge that this statement supplements and complements the University Providers Confidentiality of Information Statement. I understand that all data in UMMS information systems is confidential and shall be handled accordingly. Protected Health Information (PHI) of patients will be shared only for the purpose of providing care and fulfilling my duties. I understand that UMMS reserves the right to actively monitor all use of the information systems. I understand that use of any information system for personal reasons or in violation of UMMS' confidentiality or acceptable use policies could serve as grounds for disciplinary action.

**Requestor's Signature	**Requestor's Printed Name	**Date
	Judy A. Thomas	
**Liaison's Signature	**Liaison's Printed Name	**Date

Please print and fax completed form to Judy A. Thomas at 410-822-9457

judy.thomas@umm.edu