



7202 NE Evergreen Parkway, Suite 100  
 Hillsboro, Oregon 97124-7251  
 Voice: 503-693-4174  
 FAX: 503-693-5601  
 TTY: 711

**Oregon State Public Health Laboratory (OSPHL)**  
 Newborn Screening Secure Remote Viewer (SRV) Set-Up Form

Secure Remote Viewer (SRV) is a web-portal for providers to access newborn bloodspot screening result reports for their patients. OSPHL is requesting that you complete this access form.

**Section 1** of the form requires that you specify the name of your facility/clinic and identify a Medical Director or Authorized Provider Representative who will assume responsibility for individuals accessing the SRV portal at your facility. **Section 2** requires the contact information of all individuals who need access to the SRV portal and requires their attestation to only access medical records required for patients in your care.

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**Section 1: Facility Information and Designated Medical Director or Authorized Provider**

<b>Facility Name:</b>	<b>Facility Address(Street, City, State, Zip):</b>
<b>Facility Phone:</b>	<b>Facility Secure Fax:</b>
<b>Medical Director/Authorized Provider Name:</b>	<b>Credentials:</b>
<b>NPI:</b>	<b>Title:</b>

**Attestation Statement: Medical Director/Authorized Provider – Read this before signing.**  
*As a health care provider qualified to order laboratory tests in Oregon, I request access to the OSPHL Newborn Screening Secure Remote Viewer (SRV) for the staff listed in Section 2 below.*

*Their signature in the space provided is their attestation that they agree to the terms and conditions governing the access to and use of the protected patient information within the SRV.*

*I further state that I am authorized to make this request on behalf of the facility listed above and assure that the individual(s) named below are not being granted access rights in excess of those required to perform their legitimate job requirements. In addition, I or my designee will notify OSPHL should any of the listed individuals on this form have a change of job requirements that removes their need for access rights to perform their required job duties. My designee or I will immediately notify the OSPHL in writing or by fax should any of the individuals listed on this form terminate employment with this facility.*

Medical Director/ Authorized Provider Signature (see attestation above):	DATE:
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By typing my name I am electronically signing this application.

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**Section 2: Users for Whom Access is Requested**

Please list the staff that will need access to view screening result reports in SRV. Staff members listed do not need to be medical providers in order view the result reports.

**Attestation Statement: Staff – Read this before signing:**

*By signing, I certify that I will maintain the confidentiality of the records I am allowed to access and that the information will be used only in the authorized performance of my legitimate job requirements for this facility. By typing my name I am electronically signing this application.*

Name	Email	Signature (see attestation above)

Send completed and signed form by fax or email:

Fax to: (503) 693-5601

Email: [NWRegional.NBS@odhsoha.oregon.gov](mailto:NWRegional.NBS@odhsoha.oregon.gov)

Users will receive their username and password via the email address provided in Section 2.

**OSPHL Use Only** Entered by:

Date: