VISITING NURSE HEALTH SYSTEM PHYSICIAN PORTAL USER AGREEMENT

I understand that I have a legal obligation to keep confidential all information that I have access to through the Physician Portal. I will only discuss information accessed on the portal with others who have a need to know the information in order to perform their work. Release of unauthorized information will result in suspension of my access to the Physician Portal.

I will not intentionally attempt to gain access to information that is not needed for the performance of my work.

I understand that I am solely and fully accountable for any information entered into a computer system with my unique log in and password. I agree that I will not share my log in or password with anyone.

I will notify the Visiting Nurse Health System Compliance Officer at 404-215-6050 immediately if I suspect that someone has gained unauthorized access to my log in or password.

I will notify the Visiting Nurse Health System Compliance Officer at 404-215-6050 immediately if I receive patient information or documents through the portal for persons who are not my patients.

I understand that Visiting Nurse Health System reserves the right to monitor, review, audit, intercept, access and disclose all matters on Visiting Nurse Health System computers at any time, with our without notice and that such access may occur during or after working hours. I am aware that use of a password on a computer system does not restrict the right of Visiting Nurse Health System to access my electronic actions.

*****I understand that Visiting Nurse Health System only supports the use of the Physician Portal application. My computer hardware, software and connectivity are my responsibility.*****

My signature below acknowledges that I have read and understood the Physician Portal User Agreement and Physician Portal Policy governing access to the Physician Portal

_____ _____

Printed Name Date

_____

Signature

PHYSICIANS: ELECTRONIC SIGNATURE AGREEMENT

This letter is to acknowledge that I have been granted electronic signature privileges at Visiting Nurse Health System for completion of physician's orders for patients I have referred to Visiting Nurse Health System for home health services. I acknowledge that my access to the physician's orders will be through the Physician Portal with my own unique identification and password. I will be the only person to access my incomplete orders and sign them electronically.

I understand this document will remain in a file maintained by Visiting Nurse Health System.

_____ _____

Printed Physician Name **Date**

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Physician Signature