ELECTRONIC MEDICAL RECORDS, FORMS, AND INFORMATION ACKNOWLEDGMENT FORM

As an employee/staff member of BISHOP NURSING HOME I will be granted access to certain electronic records maintained by BISHOP NURSING HOME and Centers Health Care (CHC). In order to access the records, I will be given a user ID/password. If I am authorized to sign electronically, I will be provided with an electronic signature/unique identifier that I will use to sign electronic documents.

By signing below, I acknowledge and certify that:

- I will safeguard my user ID/password and unique identifier, as applicable, to prevent unauthorized access by others.
- I am the only person authorized to use the unique identifier/user ID/password assigned to me.
- I will not disclose /release my unique identifier/user ID/password to anyone nor allow anyone to access or alter information using my unique identifier.
- I will not use another person's user ID/password or unique identifier to access the electronic records or to sign an electronic document.
- My electronic signature and/or unique identifier is as legally binding as my traditional handwritten signature.
- If my position requires remote access to the EHR I understand that I cannot download electronic protected health information (ePHI) or print ePHI outside of the facility and that I must ensure that the information I am viewing remains private.
- I will not leave a computer station to which I am signed on unattended and I will log/sign off the system when I am finished.
- I understand that the unauthorized use of computer resources and/or electronic records is prohibited.
- I will report all security violations to my supervisor.
- I understand that violation of the electronic medical record policy and procedures will result
- in disciplinary action including, but not limited to, suspension or termination and/or civil proceedings, and/or criminal prosecution.

I have read, understood, and retained a copy of the Acknowledgement, and agree to comply with the electronic medical record policy and procedures and the terms described above.

Date _____

Facility (Required) _____

Employee/Staff member Signature (***WET INK***) _____

Print Name (Must be Legible) _____

Title (Required) _____

Department (Optional) _____

Designation /License (Required) Example(s): RN, LPN, CNA, SLP, PT, OT, LSW, APRN, RD, etc. or if none N/A _____

Salaried / Hourly /Per Diem _____

Revised: 3/3/2022