HCA
Hospital Corporation of America®

TO: Administration, Health Information Management, and Medical Staff Office
RE: Electronic Signature and Electronic Editing

I will participate in the use of electronic signature to authenticate documents on the hospital information system. The documents will be signed via the hCare System used at any of the TriStar/HCA facilities at which I have clinical privileges.

A unique identifier (personal identification number or PIN) will be used to electronically sign documents, and I understand that the PIN is confidential. I certify that I will not disclose the PIN assigned to me to any other person or permit another person to utilize it. I understand that all edits must be made in accordance with facility record completion policies. I accept responsibility for any and all edits I make to transcribed documents. I understand the use of the editing feature is restricted to reports that are available for electronic signature through the hCare System and that I am required to electronically sign any documents I have edited.

Misuse as defined by CMS is "that the physician has allowed another person or persons to use his/her PIN." Violations of this policy will be reported to the Medical Staff Executive Committee and/or Administrative personnel as addressed by facility security policies and procedures.

I agree to review each entry or document on-line prior to affixing my electronic signature. I understand that I am responsible for the content of all medical record entries that I authenticate electronically. I have been given access to the following:

_____ Electronic Authentication of all Medical Record Documents

_____ Ability to Edit Transcribed Reports

Provider Name: _____ Date: _____
(Please Print)

Provider Signature: _____

Provider E-mail Address: _____

Do you currently have remote access to HCA systems? ☐ Yes ☐ No
If No, are you interested in having remote access? ☐ Yes ☐ No