

## VCU Health System PatientKeeper Connect

### Request Instructions

#### Remote Clinical User

1. Requesting remote clinical end user must complete pages 2 and 3.
2. Please have leadership, other than yourself, complete the Site Supervisor Information on page 4. Physicians, Nurse Practitioners, and Physician Assistants may sign as their own site supervisor. ***The person that signs this page should be a leader at your practice that would be the contact person if the Office for Civil Rights (OCR) were to investigate a privacy breach and would be held responsible for any breach from your practice.*** The site supervisor will receive quarterly emails to validate employees' continued business need for access to PatientKeeper. Failure to respond will result in deletion of account.
3. Send all forms to VCU Health System via the following options:  
Fax: 804-628-2668  
Email: [vcuhsconnectsupport@mcvh-vcu.edu](mailto:vcuhsconnectsupport@mcvh-vcu.edu)

## Remote Clinical User Information

\_\_\_\_\_ **Last Name**    \_\_\_\_\_ **First Name**    \_\_\_\_\_ **Middle Name**

**Job Title:** \_\_\_\_\_  MD, NP, PA     RN, LPN, MA     Administrative

**Non-Providers: List Providers you support for patient list access:** \_\_\_\_\_

**Office Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Work Email:** \_\_\_\_\_  
(Official work email address that is accessed only by you)

**Name of Provider Clinic or Site/Business:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Purpose of Remote Access (check all that apply):**

- Referring provider for continuity of care
- Receiving provider for continuity of care – Nursing Home, Assisted Living, etc.
- Medical Necessity Review
- Utilization Review
- \_\_\_\_\_

**Anticipated Access Times (check all that apply):**

- Monday – Friday, 8 – 5
- Other Hours, please specify: \_\_\_\_\_

## Remote Clinical User Identity Verification Questions

Please answer the following questions for identification purposes. These questions will be used to verify your identity if you forget your password. Please print all answers clearly and legibly. Note: The answers to questions 2 and 4 must be different.

1. City where you were born: \_\_\_\_\_

2. A significant 4-digit number that you will not forget: \_\_\_\_\_

3. Mother's maiden name: \_\_\_\_\_

4. The year you first lived in Virginia: \_\_\_\_\_

**CONFIDENTIALITY AGREEMENT:** I acknowledge that during the course of performing my assigned duties at \_\_\_\_\_, I may have access to, use, or disclose confidential health information. I acknowledge and understand that I may have access to confidential information regarding VCU Health System (hereby referred to as "VCUHS") employees, patients, and patient care as well as proprietary or other confidential business information belonging to VCUHS (collectively "Confidential Information"). I hereby agree to handle such information in a confidential manner at all times, even if I no longer have access to PatientKeeper. By signing below, I certify that I have read this agreement and hereby commit to the following obligations:

- A. I will use and disclose Confidential Information only in connection with and for the purpose of performing my assigned duties.
- B. I will request, obtain or communicate Confidential Information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more Confidential Information than is necessary to accomplish my assigned duties. I understand that accessing Confidential Information to satisfy personal curiosity is strictly forbidden.
- C. I will not share Confidential Information that I have access to with persons who are not authorized to have access to it or do not have an appropriate 'need to know'.
- D. I understand that all VCUHS information system access is subject to security monitoring and auditing; VCUHS will take appropriate action when improper uses are detected.
- E. I will take reasonable care to properly secure Confidential Information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver in order to prevent access by unauthorized users.
- F. I will not disclose my User ID or personal password(s) to anyone without the express written permission of VCUHS or record or post it in an accessible location. I will refrain from performing any tasks using another's password or User ID.
- G. I understand that the use and disclosure of patient information is governed by the rules and regulations established under the Health Insurance Portability and Accountability Act and its attendant regulations, as amended ("HIPAA"), Virginia law, and related policies and procedures of VCUHS. I will use and disclose Confidential Information solely in accordance with the law and policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such laws and policies in a timely manner.
- H. I will immediately report any unauthorized use or disclosure of Confidential Information that I become aware of to the appropriate supervisor and to the VCUHS Privacy Officer by phone (1-800-620-1438) or by email ([complianceservices@vcuhealth.org](mailto:complianceservices@vcuhealth.org)).

**ACKNOWLEDGMENT AND AGREEMENT:** Remote Access to the VCUHS network is a privilege, which VCUHS may terminate at any time in its sole discretion. I hereby acknowledge and agree that remote access is authorized for my use only and I will use it solely to obtain information for healthcare treatment or operations purposes that are directly related to my organization's relationship with VCUHS. I further agree to keep at all times any passwords and user names confidential and not to share them with any third party and to immediately report any breach of my obligations hereunder. By requesting a remote access account, I acknowledge that I will install or already have installed virus protection software on my remote system (this includes business and home computers and laptops, or any other system used to access VCUHS Confidential Information) system. Installation of virus protection and applying virus signature updates is my responsibility. I understand that failure to do so may result in loss of remote access privileges. VCUHS employees are not responsible for any operating system, hardware or software application problems encountered by any VCUHS Remote Access User when using the designated applications to connect to the VCUHS network(s).

I understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in action, up to and including revocation of system privileges and/or termination of relationship with VCUHS, and where applicable, criminal charges.

By signing below, I indicate that I have read, understand and agree with the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)



## Site Supervisor (Manager/Director/Physician) Information

Physicians, Nurse Practitioners, and Physician Assistants may sign as their own site supervisor. The person who signs this page should be a leader at your practice who would be the contact person if the Office for Civil Rights (OCR) were to investigate a privacy breach and would be held responsible for any breach from your practice. The site supervisor receives quarterly emails to validate employees' continued business need for access to PatientKeeper. Failure to respond will result in deletion of account.

\_\_\_\_\_  
**Last Name**                                      **First Name**                                      **Middle Name**

**Job Title:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Individual Email:** \_\_\_\_\_

**HIPAA Training Attestation:** I attest that requesting user \_\_\_\_\_ receives annual training on the Health Insurance Portability and Accountability Act (HIPAA) and will continue to receive annual HIPAA training as long as he/she has access to PatientKeeper and the protected health information of VCU Health System patients. I will provide VCU Health System with evidence of such training annually for user to maintain access.

NOTE: The Department of HHS offers free Privacy Guidance and Training: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/index.html>

**Date of requesting user's most recent HIPAA Training:** \_\_\_\_\_

**ACKNOWLEDGMENT AND AGREEMENT:** Remote Access to the VCU Health System (hereby referred to as "VCUHS") network is a privilege which VCUHS may terminate at any time in its sole discretion. By signing below, I acknowledge and agree to the following:

1. Remote access is authorized for the use of my employee/contractor and I will ensure that it is solely used to obtain information for healthcare treatment or operations purposes that are directly related to my organization's relationship with VCUHS.
2. My employee(s) shall keep at all times any passwords and user names confidential, and not to share them with any third party, and to immediately report any breach of my organization's obligations, or the obligations of my employee/contractor.
3. By requesting a remote access account, I acknowledge that I will install or already have installed virus protection software on my remote system (this includes business and home computers and laptops, or any other system used to access VCUHS Confidential Information). Installation of virus protection and applying virus signature updates is my responsibility.
4. VCUHS employees are not responsible for any operating system, hardware or software application problems encountered by any VCUHS Remote Access User, when using the designated applications to connect to the VCUHS network(s). My employee has signed the Confidentiality Agreement and I am aware of the terms and conditions of the agreement.
5. I shall immediately notify VCUHS if my employee is no longer employed or does not need access to the VCUHS network for any reason.
6. Under no circumstance shall VCUHS be liable to any non-VCUHS clinical information application user for any direct, indirect, consequential, incidental, special or exemplary damages under any theory of liability, even if such party has been apprised of the possibility or likelihood of such damages occurring. My organization shall defend, indemnify and hold harmless VCUHS and its affiliates from and against any and all costs, liabilities, expenses and fees related to a third party claim (including but not limited to governmental investigations) arising from my organization's use of VCUHS' clinical information applications.
7. I understand that failure to meet these requirements do so may result in loss of remote access privileges.

**Accepted and Agreed:**

\_\_\_\_\_  
Name of Organization

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Date