VCU Health System PatientKeeper Connect

Request Instructions

Remote Clinical User

1. Complete pages 2, 4, and 5. All items are required.
2. Please have leadership, other than yourself, complete and sign as Site Supervisor on page 3. 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 receives quarterly emails to validate employees’ continued business need for access to PatientKeeper. Failure to respond will result in deletion of account.
3. Send forms to VCU Health System via the following options:
   Fax: 804-628-2668
   Email: vcuhsconnectsupport@mcvh-vcu.edu

VCU Health System Sponsor

1. Verify Site Supervisor is correct for account approval request and signature.
2. Complete Page 6 to authorize the remote clinical access.
3. Enter request into PatientKeeper Users Referring Physician List.
4. Provide login credentials to user once received by PatientKeeper Support.

PatientKeeper Support

1. Complete Page 7 for review and approval
2. Create new account in PatientKeeper.
3. Notify VCU Health Sponsor of user name and password.

Report all breaches immediately to VCU Health System Privacy Officer at compliance@vcuhealth.org or 1-800-620-1438

Please fax all completed forms to (804) 628-2668

Updated October 11, 2018 EHR Use Only
# Remote Clinical User Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**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: ____________________________

**ACKNOWLEDGMENT AND AGREEMENT:** Remote Access to the VCU Health System network is a privilege which VCU Health System 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 provide the contracted services. 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 (this includes business, home or laptop) 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. VCU Health System employees are not responsible for any operating system, hardware or software application problems encountered by any VCU Health System Remote Access User, when using the designated applications to connect to the VCU Health System network(s). By signing below, I indicate that I have read, understand and agree with the above.

_____________________________  ____________________________
**Signature**  **Date**

---

Name (Printed)

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*Updated October 11, 2018 EHR Use Only*
Site Supervisor (Manager/Director/Physician) Information

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 network is a privilege which VCU Health System may terminate at any time in its sole discretion. I hereby acknowledge and agree that remote access is authorized for the use of my employee/contractor and I will ensure that it solely used to provide the contracted services. I further agree that my employee must 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, or the obligations of my employee/contractor, hereunder and will be responsible for his/her acts or omission. By requesting a remote access account, I acknowledge that I will install or already have installed virus protection software on my remote (this includes business, home or laptop) 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. VCU Health System employees are not responsible for any operating system, hardware or software application problems encountered by any VCU Health System Remote Access User, when using the designated applications to connect to the VCU Health System network(s). My employee has signed the Confidentiality Agreement and I am aware of the terms and conditions of the agreement. I agree to notify VCU Health System immediately if my employee is no longer employed or does not need access to the VCU Health System network for any reason.

_____________________________________________  ____________________________
Signature        Date

_____________________________________________
Name (Printed)

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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.

____________________________________________________
Name (Printed)

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: _____________________________________________________

Note: The answers to questions 2 and 4 must be different
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 employees, patients, and patient care as well as proprietary or other confidential business information belonging to VCU Health System. I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties.

B. I will request, obtain or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties. I understand that accessing system data to satisfy personal curiosity is strictly forbidden.

C. I will not share patient data 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 VCU Health System information system access is subject to security monitoring and auditing; VCU Health System will take appropriate action when improper uses are detected.

E. I will take reasonable care to properly secure confidential health 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 VCU Health System or record or post it in an accessible location and 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 HIPAA, the Health Insurance Portability and Accountability Act, and related policies and procedures of VCU Health System. I will use and disclose confidential health information solely in accordance with the federal regulations and policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.

H. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate supervisor and to VCU Health System.

I also 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 VCU Health System, and where applicable, criminal charges.

_____________________________________________  ____________________________
Signature        Date

_____________________________________________
Name (Printed)

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### VCU Health System PatientKeeper Connect Authorization Form

<table>
<thead>
<tr>
<th>Sponsor Name:</th>
<th>Sponsor Team:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Virginia Coordinated Care</td>
</tr>
<tr>
<td></td>
<td>☐ Outreach</td>
</tr>
<tr>
<td></td>
<td>☐ Care Coordination</td>
</tr>
<tr>
<td></td>
<td>☐ Telemedicine</td>
</tr>
<tr>
<td></td>
<td>☐ Children’s Hospital of Richmond at VCU</td>
</tr>
<tr>
<td></td>
<td>☐ Health Information Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sponsor Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sponsor Decision:</th>
<th>Support for Decision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Approved</td>
<td></td>
</tr>
<tr>
<td>☐ Denied</td>
<td></td>
</tr>
</tbody>
</table>

### Requested Access

<table>
<thead>
<tr>
<th>MD, NP, PA</th>
<th>RN, LPN, MA</th>
<th>Administrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ List of patients with a relationship established</td>
<td>☐ Ability to search: DOB or MRN (circle one)</td>
<td>☐ Ability to search: DOB or MRN (circle one)</td>
</tr>
<tr>
<td>☐ Ability to add patients to list: DOB or MRN (circle one)</td>
<td>☐ See providers’ patient lists:</td>
<td>☐ See providers’ patient lists:</td>
</tr>
<tr>
<td></td>
<td>List providers:</td>
<td>List providers:</td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td>______________________________</td>
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<tr>
<td></td>
<td>______________________________</td>
<td>______________________________</td>
</tr>
</tbody>
</table>
VCU Health System PatientKeeper Team Application Review

<table>
<thead>
<tr>
<th>Review Task</th>
<th>Complete Yes (Y) or (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Each page of application is complete</td>
<td></td>
</tr>
<tr>
<td>2. Site Supervisor on application matches Clinic/Location Supervisor.</td>
<td></td>
</tr>
<tr>
<td>Note: Providers can sign as their own supervisor, but clinic/location</td>
<td></td>
</tr>
<tr>
<td>intake form needs to be on file.</td>
<td></td>
</tr>
<tr>
<td>3. Confirm HIPAA Training Date in last 365 Days</td>
<td></td>
</tr>
<tr>
<td>4. If application is for an Admin Role, verify number of admins currently</td>
<td></td>
</tr>
<tr>
<td>at location.</td>
<td></td>
</tr>
<tr>
<td>a. If currently 2 of more admins, proceed to step 5.</td>
<td></td>
</tr>
<tr>
<td>b. Otherwise, document number of admin. Proceed to signature</td>
<td></td>
</tr>
<tr>
<td>5. Contact Site supervisor to verify the following:</td>
<td></td>
</tr>
<tr>
<td>a. What does this user do that the other users are not able to provide?</td>
<td></td>
</tr>
<tr>
<td>a. Are there users we can remove?</td>
<td></td>
</tr>
<tr>
<td>b. Please provide the justification to proceed with the account creation.</td>
<td></td>
</tr>
</tbody>
</table>

Site Supervisor

Justification is required for account:

Application Review Approved or Denied

Create Account___________
Return to Sponsor_________

PK Team Member

_______________________________________________  Date

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