



VCU Health System PatientKeeper Connect

Request Instructions

Remote Clinical User

1. Complete pages 2, 4, and 5. All items are required.
2. Have your Site Supervisor complete and sign page 3.
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 5 to authorize the remote clinical access.
3. Complete any additional approvals required by senior leadership.
4. Enter request into PatientKeeper Users Referring Physician List.
5. Will provide login credentials to user once received by PatientKeeper Support.

PatientKeeper Support

1. Create new account in PatientKeeper.
2. Notify VCU Health System sponsor of user name and password.
3. Forward copy of signed Acknowledgements to Site Supervisor.

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

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

Updated March 30, 2017



Remote Clinical User Information

Last Name First Name Middle Name

Job Title: MD, NP, PA RN, LPN, MA Administrative

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:

- 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 clinical treatment and patient care services for my patients. 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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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 upon request.

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 clinical treatment and patient care services for my patients. 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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Page 3

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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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Page 5

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VCU Health System PatientKeeper Connect Authorization Form

Sponsor Name:	Sponsor Team:	
Sponsor Signature:	<input type="checkbox"/> Virginia Coordinated Care <input type="checkbox"/> Outreach <input type="checkbox"/> Care Coordination <input type="checkbox"/> Telemedicine	
Date:	<input type="checkbox"/> Children's Hospital of Richmond at VCU <input type="checkbox"/> Health Information Management	
Sponsor Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Support for Decision:	
Requested Access		
MD, NP, PA	RN, LPN, MA	Administrative
<input type="checkbox"/> List of patients with a relationship established <input type="checkbox"/> Ability to search: DOB or MRN (circle one) <input type="checkbox"/> Ability to add patients to list: DOB or MRN (circle one)	<input type="checkbox"/> Ability to search: DOB or MRN (circle one) <input type="checkbox"/> See providers' patient lists: List providers: _____ _____ _____	<input type="checkbox"/> Ability to search: DOB or MRN (circle one) <input type="checkbox"/> See providers' patient lists: List providers: _____ _____ _____

Leadership Approval

Approved Denied

Approved Denied

 John Ward, M.D.
 President, MCV Physicians

 Ron Clark, M.D.
 Chief medical officer and vice president for clinical activities, VCU Health System