HCA
Hospital Corporation of America®

Methodist Healthcare System
8109 Fredericksburg Road
San Antonio, TN 78229
(210) 575-0200

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 the following facilities in which I have clinical privileges:

Methodist Hospital	Methodist Ambulatory Surgical Hospital
Methodist Children's Hospital*	Methodist Stone Oak Hospital
Methodist Heart Hospital*	Methodist Ambulatory Surgical Hospital
Metropolitan Methodist Hospital*	Methodist Ambulatory Surgery Center - Medical Center
Northeast Methodist Hospital*	Methodist Ambulatory Surgery Center - North Central
	Methodist Specialty & Transplant Hospital*

*A facility of Methodist Hospital

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." The Texas Computer Crime Statute state to intentionally or knowingly give your PIN or password to another individual is a misdemeanor. 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 within any of the applications listed below:

Electronic Authentication of all Medical Record Documents
Ability to Edit Transcribed Reports
Electronic Authentication of Electronic Orders (ePOM)
Electronic Physician Order Management e-Prescribe documents (inpatient and outpatient)

Provider Name: _____ Date: _____
(Please print)

Provider Signature: _____

IMPORTANT: How would you like to be contacted?

Phone/Cell/Pager: _____

E-mail (include to receive printed instructions) _____

Fax number: _____