



HEALTH SYSTEM / COMPUTING SYSTEM ELECTRONIC ACCESS AGREEMENT

Name (PLEASE PRINT): _____

Date: _____

I will not disclose my password(s) to other individuals, and acknowledge that my password is equal to my electronic signature.

I understand that I will be held responsible for the consequences of any misuse occurring under my user ID and password(s) due to any neglect on my part.

I agree to follow the privacy, security and other computing policies and procedures established by the University and the Medical Center for the use of my password(s) and the systems that I will have access to.

I agree to perform only transactions that affect the patients and/or accounts for which I have responsibility or authorization, and not to view information that I have no need to see as part of my responsibilities.

I will respect the confidentiality of individuals to whose records I have been given access.

My signature below indicates that I have read, understand, and agree to abide by these requirements.

Signature: _____

Social Security No./UVA Employee ID: _____

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