**AUTHORIZATION FOR ELECTRONIC SIGNATURE USE**

**CONFIDENTIALITY AGREEMENT**

**HENDRICK MEDICAL CENTER**

I certify that my user identification and password identifier represents my signature and, as such, carries all the ethical and legal implications of a written signature. I will not disclose this personal password identifier to any other person or permit another user to use it. I understand that the patient information is confidential and agree to follow Hendrick Medical Center Policies and Procedures, and Rules and Regulations of the Medical Staff, pertaining to patient confidentiality. I understand that failure to maintain both patient confidentiality and confidentiality of my personal password will result in the forfeit of my rights to use the electronic signature function.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature