Health Care Agency

ELECTRONIC SIGNATURE APPLICATION

DHCS Legal Entity Name: _____

DHCS Legal Entity Number: _____

County approval should be sent to:

Name: _____

Address:_____

I certify that the electronic signatures affixed to the electronic behavioral health records on the computer systems employed by or on behalf of_____, a Legal Entity, and its sub-contract providers meet or exceed all of the standards, information security considerations, regulations and laws as listed in the Department of Health Care Services (DHCS), formerly DMH – DMH LETTER NO.: 08-10 and/or ADP Bulletin 10-01, but not limited to the aforementioned State documents, and future applicable laws and regulations as they develop.

I have obtained a signed Electronic Signature Agreement (ESA) from every current clinician/provider/supervisor/staff who will use the electronic signature features of the electronic health record.

I will obtain an Electronic Signature Agreement from every new clinician/provider/ supervisor/staff prior to their use of the EHR. I will remove every clinician/provider/ supervisor/staff electronic signature privileges form the EHR upon termination of employment.

I will keep the ESA on file, for each staff, and produce the ESAs when necessary for audit or review.

_____ _____

Signature of Executive Director or Designee Date

_____ _____

Printed Name of Executive Director or Designee Date