Santa Barbara County Department of Behavioral Wellness

Electronic Signature Agreement

Submit Electronic Signature Agreement to:
BWELLHelpDesk@sbcbwell.org or BWELLADPTEAM@sbcbwell.org

Please allow up to 5 business days for the request to be processed

1. This Agreement governs the rights, duties, and responsibilities involving the use of an electronic signature in Santa Barbara County.
2. I, the undersigned, understand that a password which is used to establish my identify, obtain access to computer systems, and/or enter information into computer systems operated or under the control of Santa Barbara county constitutes an electronic signature for the purposes of this Agreement.
3. I agree to the following terms and conditions:
    a. I will use my electronic signature to establish my identity and sign electronic documents and forms.
    b. My electronic signature will be valid for a maximum of one year from date of issuance. I will be notified and given the opportunity to select a new password at least annually. Selecting a new password renews the terms of this Agreement.
    c. I agree to keep my electronic signature secret and secure by taking reasonable security measures to prevent unauthorized access, disclosure, loss, modification, compromise, or use of my electronic signature or any medical on which information about it is stored. If I suspect or discover that my electronic signature has been stolen, lost, used by an unauthorized party, or otherwise compromised, I will immediately notify the Santa Barbara County Department of Behavioral Wellness Quality Assurance program by phone at (805) 681-4777 and request that my electronic signature be revoked. I will then immediately cease all use of my electronic signature until a new password is assigned to me.

4. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Important: check which system you are submitting signature for below and submit to email address indicated below:

☐ Alcohol and Drug Program (ADP) please email form to ADP:

BWELLADPTEAM@sbcbwell.org

☐ Mental Health System (MHS) please email form to the helpdesk:

BWELLHelpDesk@sbcbwell.org

Print Full Name (please print clearly):	
Facility Phone Number:	
Signature:	Date:
Agency:	

Alcohol and Drug Program Administrator Signature: (ADP only)

Signature:	**Date:**