AUTHORIZED USER AGREEMENT

NORTH DAKOTA INFORMATION TECHNOLOGY
HEALTH INFORMATION NETWORK
SFN 60297 (04-2023)

The North Dakota Health Information Network (NDHIN) allows health care providers to electronically access, use, and disclose patient health information. Information is encrypted and sent over a secure network. The North Dakota Information Technology Department (NDIT) is required by statute N.D.C.C. § 54-59-26(b) to implement and administer a health information exchange.

Please print clearly. *Required. (Hover over field text for help.)

Name of NDHIN Participant (Health Care Organization)*		User ID	
Authorized User's Name*	Title*	E-mail Address*	
National Provider Identifier (NPI) (Personal NPI for Primary Provider or Pharmacist, Facility NPI or N/A for other users)*			
Facility Address*	City*	State*	ZIP Code*

Role:*
Choose at least one role that matches the user's job function.

- ☐ Physician, Nurse Practitioner, Mid-level
  - Specialty
- ☐ Nurse
- ☐ Pharmacist
- ☐ Therapist, Care Support, Unit Clerk, Medical Assistant, Tumor Registrar, Vocational Rehab, Autopsy Assistant, Coroner, Contact Tracer, Epidemiologist, Social Worker, EMS, etc.
- ☐ Health Plan, Insurance
- ☐ Front Desk (ex. Billing Clerk, Registration Staff)
- ☐ Privacy Officer
- ☐ Testing
- ☐ Other - Specify: _____

Participants and the NDHIN monitor the impermissible access, use or disclosure of patient health information by Authorized Users. Impermissible access, use or disclosure may result in disciplinary action and termination of this agreement and a breach could result in personal liability for damages.

As an Authorized User you agree to the following terms and conditions.

1. I will only access, use, or disclose an Individual's Protected Health Information (PHI) with whom I have a health care relationship; for treatment, payment processing, or other necessary business related to the Individual in the performance of my duties.
2. I agree to access, use or disclose only the minimum necessary amount of an Individual's PHI necessary for the performance of my duties.
3. I agree to maintain the confidentiality of PHI as required under the HIPAA Rules, Federal and State Laws and Regulations, and Administrative Rules applicable to an Individual's health information.
4. I agree to abide by the NDHIN policies.
5. I acknowledge the HIPAA and NDHIN confidentiality requirements continue beyond my employment with the Participant.
6. I acknowledge that I must participate in annual privacy and security training as a member of the Participant's workforce.

I HAVE READ AND AGREE TO COMPLY WITH THE NDHIN AUTHORIZED USER AGREEMENT.

Authorized User's Signature	Print Name	Date
Signature of individual designated by Participant to authorize this User Agreement	Print Name	Date