AUTHORIZED USER AGREEMENT

NORTH DAKOTA INFORMATION TECHNOLOGY
HEALTH INFORMATION NETWORK
SFN 60297 (11-2020)

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 (ITD) is required by statute N.D.C.C. § 54-59-26(b) to implement and administer a health information exchange.

Please print clearly.

Name of NDHIN Participant (Health Care Organization)			User ID
Authorized User's Name	Title		Specialty
E-mail Address	Communicate (Direct Secure Messaging) E-mail Address		
National Provider Identifier (NPI) (Personal NPI for Primary Provider, Facility NPI for all other users)			
Facility Address	City	State	ZIP Code

You have been designated to be an Authorized User with the following functions:

Production

- ☐ Primary Provider (ex. Physician, Nurse Practitioner)
  - Specialty
- ☐ Secondary Provider (ex. Nurse, Therapist, Pharmacist)
  - ☐ Nurse
  - ☐ Pharmacist
  - ☐ Therapist
- ☐ Care Support (ex. Unit Clerk, Medical Assistant)
- ☐ Health Plan
- ☐ Front Desk (ex. Billing Clerk, Registration Staff)
- ☐ Privacy Officer
- ☐ Other - Specify: _____

PDMP (Prescription Drug Monitoring Program)

- ☐ Provider
- ☐ Pharmacist
- ☐ Nurse

eHealth Exchange Gateway Role (Query other HIEs and Federal agencies)

- ☐ Provider
- ☐ Pharmacist
- ☐ Nurse

Testing

- ☐ Validation Testing

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		Date
Participant (Health Care Organization) Granting Authority's Signature	Name	Date

Please return to NDHIN via email at ndhin@nd.gov