

## **eAUA (Electronic AUA) Process – Granting Authority**

1. NDHIN provides the eAUA link as well as the eAUA Email Script to the Granting Authority: Page 7. The participant edits Page 7 by replacing the black script in the screenshot below with the name and email address of the granting authority who will approve the AUA.

**When you are asked to assign the NEXT PARTICIPANT, enter:  
{Participant Granting Authority enter name and email here}**

2. Granting Authority emails the eAUA link and instruction email to person(s) requiring NDHIN access: Page 7.
3. User clicks on the URL provided by their facility.
4. User clicks 'Continue' at bottom of page.



**AUTHORIZED USER AGREEMENT**  
 NORTH DAKOTA INFORMATION TECHNOLOGY  
 HEALTH INFORMATION NETWORK  
SFN 60297v2 (12-2022)

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. § 54-59-28(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*

Choose the role that matches the user's job function.

Role: \* Select...  
 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 <small>* Click here to sign</small>	* Print Name	Date 02/09/2023
Signature of individual designated by Participant to authorize this User Agreement	Print Name	Date

By clicking continue, I acknowledge that I have read and agree to the Above Terms of Use. See our Privacy Policy for details on our privacy practices.
Continue

5. User completes and signs the form. Note that required fields have orange asterisks. Click 'Click to Sign' at the bottom of the form.



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**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*

Choose the role that matches the user's job function.

Role:   Other

Select...  
 Provider  
 Nurse  
 Pharmacist  
 Other Clinical Roles  
 Front Desk  
 Health Plan  
 Privacy Officer

As an  I agree to monitor the impermissible access, use or disclosure of patient health information by Authorized Users. Disclosure may result in disciplinary action and termination of this agreement and a breach could result in disciplinary action.

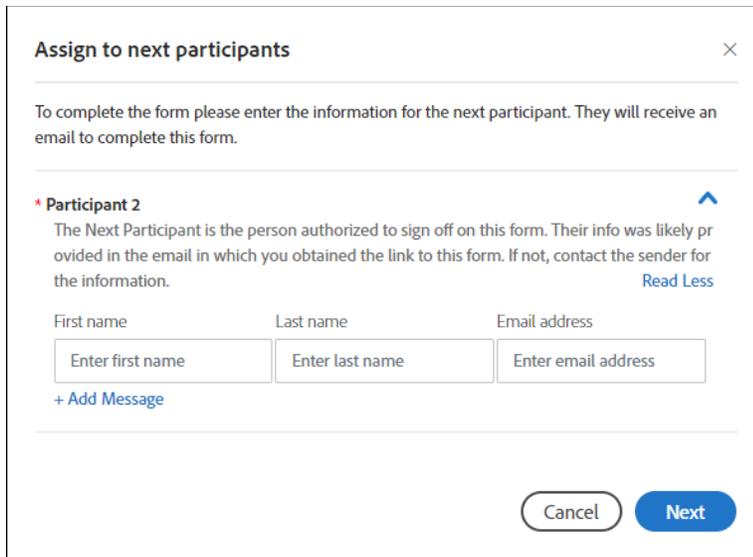
I agree to abide by the following terms and conditions.

- 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.
- I agree to access, use or disclose only the minimum necessary amount of an Individual's PHI necessary for the performance of my duties.
- 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.
- I agree to abide by the NDHIN policies.
- I acknowledge the HIPAA and NDHIN confidentiality requirements continue beyond my employment with the Participant.
- 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 <small>* Click here to sign</small>	Print Name	Date 02/09/2023
Signature of individual designated by Participant to authorize this User Agreement	Print Name	Date

- After signing the form, User enters the provided name and email for their Granting Authority into the Participant 2 fields:



**Assign to next participants** [X]

To complete the form please enter the information for the next participant. They will receive an email to complete this form.

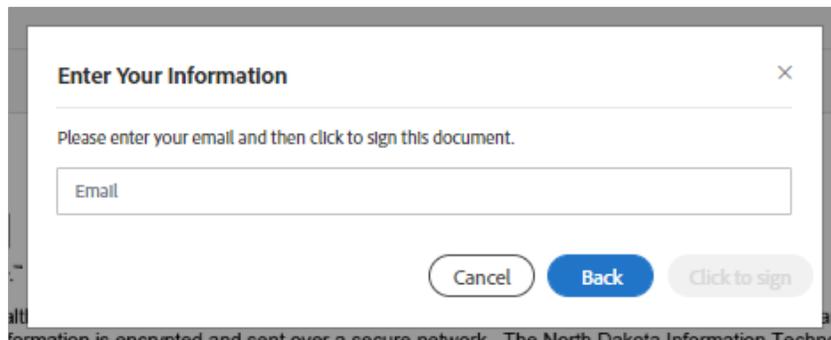
**\* Participant 2** [Up Arrow]

The Next Participant is the person authorized to sign off on this form. Their info was likely provided in the email in which you obtained the link to this form. If not, contact the sender for the information. [Read Less](#)

First name	Last name	Email address
<input type="text" value="Enter first name"/>	<input type="text" value="Enter last name"/>	<input type="text" value="Enter email address"/>

[+ Add Message](#)

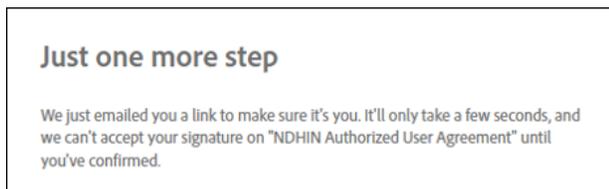
- User provides their own email which triggers an authentication email to the user.



**Enter Your Information** [X]

Please enter your email and then click to sign this document.

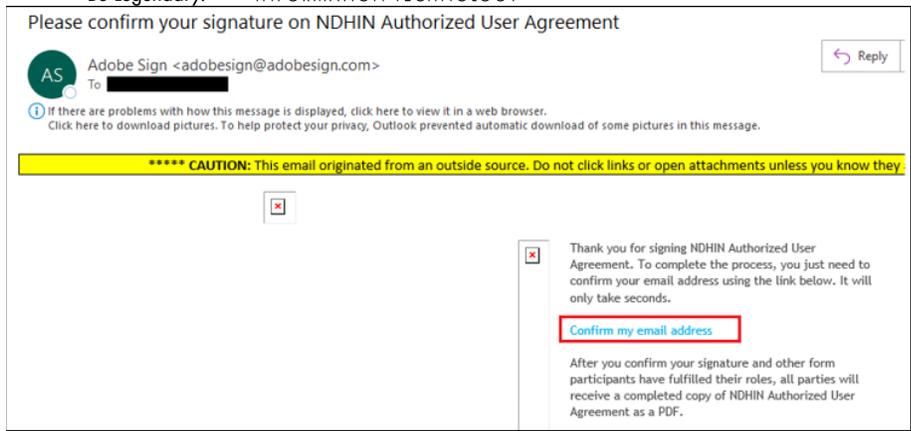
- User is presented with this message.



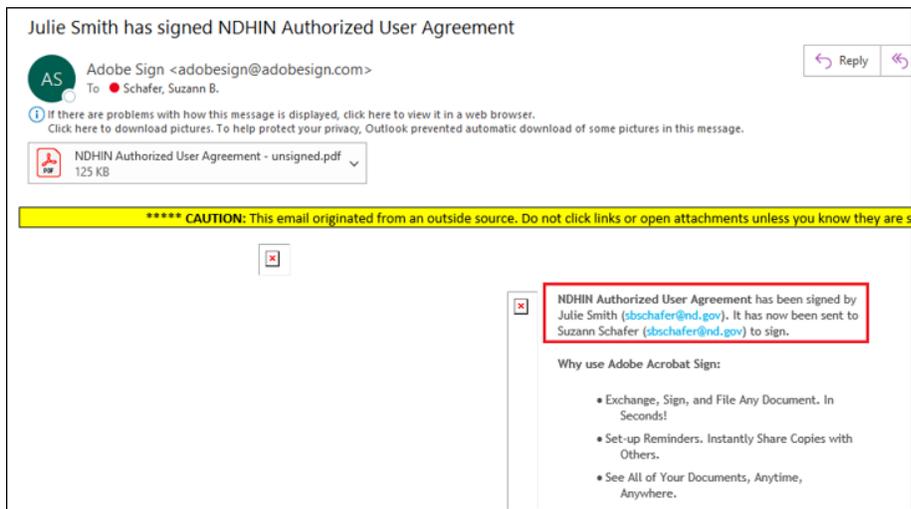
**Just one more step**

We just emailed you a link to make sure it's you. It'll only take a few seconds, and we can't accept your signature on "NDHIN Authorized User Agreement" until you've confirmed.

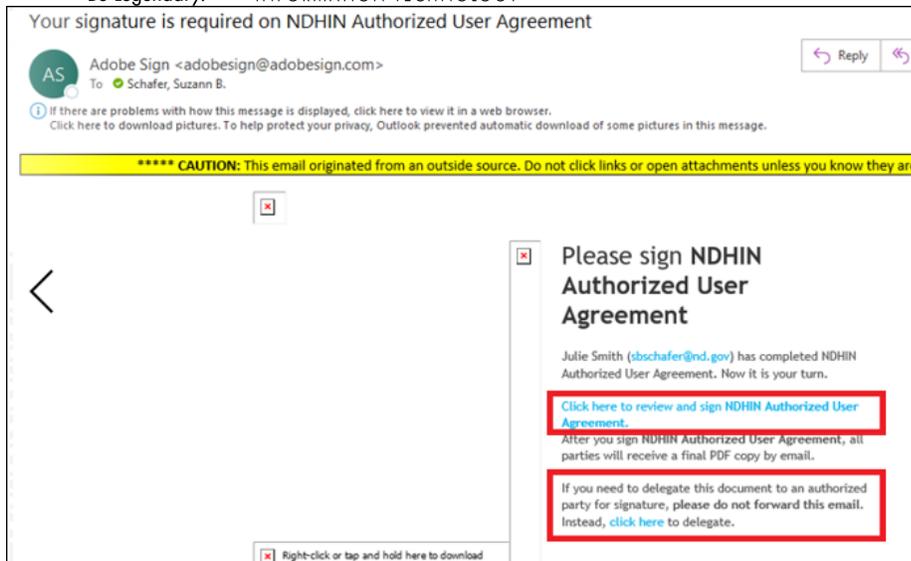
- User opens their email, finds the authentication email, and confirms their email address by clicking on the blue sentence 'Confirm my email address'.



10. Granting Authority receives an email notification that an eAUA has been signed. Please note the two names in the red box, below.
- The user requesting access will be the first name and the second name MUST be the name of the granting authority.
  - If the second name is not the granting authority, you must contact the user and ask them to start over by clicking the link and filling out a new form. Inform the user that they must put the granting authority's name and email in the 'Assign the Next Participants' box.



11. Granting Authority receives a second email giving them the option to either Review and Sign or to Delegate the approval signature to another person.



12. If delegation is chosen, these boxes are completed. Only the person to whom the signature is delegated will see the message.

Delegate this document

To send this document to another individual in your organization for signature, enter their email address and a message below.

Email:

Message:

Delegate

13. Granting Authority adds the User ID only if the organization is using Single Sign On, and then reviews and signs the document. The Granting Authority clicks 'click to sign' at the bottom of the form.

NORTH  
**Dakota** AUTHORIZED USER AGREEMENT  
NORTH DAKOTA INFORMATION TECHNOLOGY  
HEALTH INFORMATION NETWORK  
Be Legendary.™ SFN 60297 (11-2020)

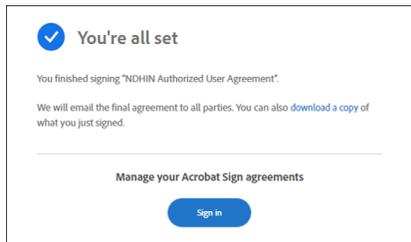
The North Dakota Health Information Network (NDHIN) allows health care providers to electronically access, use, and disclose patient health information. Information is encrypted and sent over a secure network. The North Dakota Information Technology Department (ITD) is required by statute N.D.C.C. §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

Please print clearly.

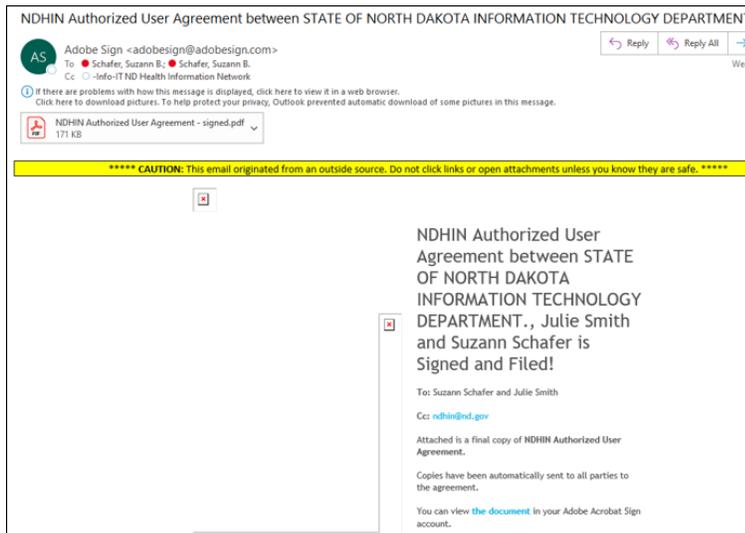
Name of NDHIN Participant (Health Care Organization)		User ID
Windsor Hospital		
Authorized User's Name	Title	Specialty
Julie Smith	RN	

I HAVE READ AND AGREE TO COMPLY WITH THE NDHIN AUTHORIZED USER AGREEMENT.		
Authorized User's Signature <i>Julie Smith</i> <small>Julie Smith (Sep 18, 2022 10:58 CDT)</small>		Date 09/19/2022
Participant (Health Care Organization) Granting Authority's Signature *Click here to sign	Name	Date 09/19/2022

14. Message opens stating the process is complete. A copy of the completed form can be downloaded at this time, and all parties will receive a copy of the completed form.



15. Email received by User, Granting Authority, and NDHIN.



16. Weekly, NDHIN downloads the all the information in the AUAs received in the prior week. That file is submitted to the NDHIN vendor, Orion. Orion creates the users, sends the new user and the password emails to the new user.

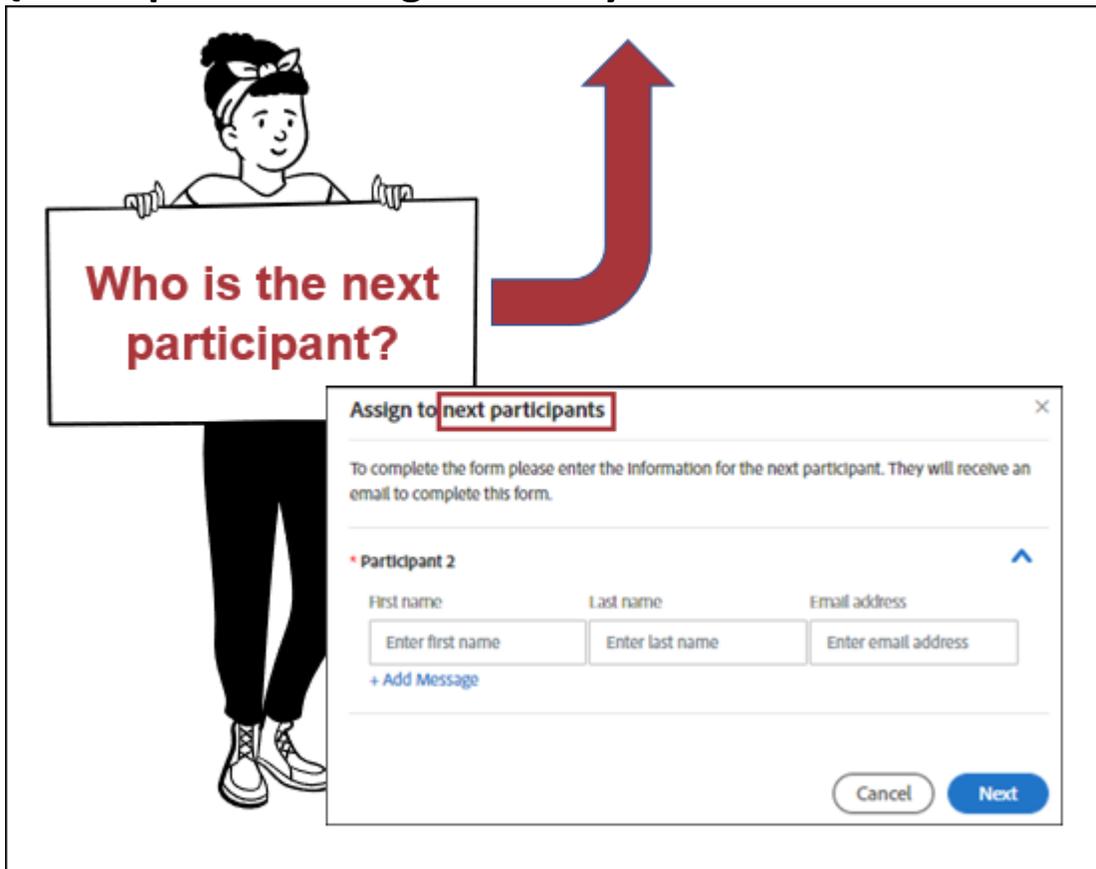
17. Urgent new user AUAs will still be processed upon request.

18. The granting authority will no longer receive the email notifying them that user setup is complete. The email displayed in step 16 will serve as notification that the user request was received by NDHIN.

[NDHIN Authorized User Agreement Link](#)

Click the above link to open the NDHIN Authorized User Agreement electronic form. Follow the attached instructions to complete the form. You will receive an email once your user account is created.

**When you are asked to assign the NEXT PARTICIPANT, enter:  
{Participant Granting Authority enter name and email here}**



Please remember: As an authorized user of the North Dakota Health Information Network (NDHIN) Clinical Portal you have agreed to access only the patients and patient data that is necessary to do your job. Additionally, NDHIN policy states: NDHIN shall limit the right of an Individual to access their own PHI or that of a family member. Additional information on NDHIN policies can be found at <https://www.ndhin.nd.gov/about-us/ndhin-policies>.