Request for access to the RIDE Immunization Registry

PLEASE PRINT CLEARLY AND COMPLETE ITEMS IN BOLD

This is a request from:

Provider/Agency Name _____

Clinic/School (if applicable) _____

Street Address _____ **City** _____ **State** ____ **ZIP** _____

Site Phone (____) _____ - _____ ext. _____ **Site Fax** (____) _____ - _____ ext. _____

Contact Name _____

Contact Phone (____) _____ - _____ ext. _____ **Contact Email** _____

to authorize _____|_____|_____| _____
(First Name) **(Middle Name)** **(Last Name)** **(Suffix)**

to access the web based California Immunization Registry – Region IV / RIDE system (Registry) and to receive the required orientation and training from Registry staff.

User Information:

Office Phone (____) _____ - _____ ext. _____ **Office Email** _____

Personal Phone (____) _____ - _____ ext. _____ **Personal Email** _____

*(This information will **only** be used to contact you in case you cannot be contacted using the Office Phone/Email.)*

Changing Name? **Current user ID** _____ **New Name** _____

Type of access requested (Check one):

- ❑ **Read-only (for lookup; no ability to update the Registry database)**
- ❑ **Read and update rights (to look up and update Registry data as necessary)**
- ❑ **Clinic Admin rights (to have Inventory and Reminder/Recall abilities)**

Do You Ever Give Immunizations or TB Tests? ❑ **YES** ❑ **NO**

The person named above agrees:

1. To access the Registry only through use of registry approved access procedures.
2. Not to browse the Registry.
3. Not to disclose Registry access codes or protocols to unauthorized persons.
4. Passwords and accounts are not to be stored electronically (i.e. by a web browser), written down, or shared with any other person or system.
5. To be responsible for ensuring that only authorized personnel have access to Registry data; any lapse in enforcing security by the provider results in the provider being disqualified from participation in the Registry.
6. To use the information obtained from the Registry only to provide immunization services, appropriate outreach to patients/clients, or other purposes lawfully allowed.
7. To maintain the confidentiality of patient information obtained from the registry as required of medical records, including HIPAA guidelines. I/ Provider/Agency understand(s) that inappropriate disclosures of this information will subject me/ him/her to civil and criminal penalties 56.35, 56.36, 1798.53 and 1798.57 of the civil code.
8. To disclose to patient/parent/guardian that information from the patient's record will be shared with other providers, health plans, schools, daycare, WIC programs, Cal Works, local and state health departments, third party payers and any others allowed by law to share.
9. To inform patient/parent/guardian of their rights to refuse to have information shared.

10. To inform patient/parent/guardian of their right to refuse to receive immunization reminder or recall notices.
11. To inform patient/parent/guardian of their right to inspect and point out errors in the Registry record and of their right to be informed of who has accessed the record.
12. To forward to San Joaquin County Public Health Services any requests for review of patient information, list of who has accessed patient's records, or refusal to receive reminders.
13. To report any suspected or confirmed breach of security or confidentiality which has occurred to San Joaquin County Public Health Services immediately upon discovery.
14. That Registry data on any removable storage media shall be rendered unrecoverable before discarding or disposing of the storage media.
15. That any hard copy produced by the Registry that contains confidentiality data will be shredded before disposal.

I have read and understand my responsibilities as stated above. I also understand that if I violate any of these policies I will be held personally responsible and my rights to the Registry may be suspended.

User Signature _____ Title _____Date___/___/_____

Supervisor Authorization The agency representative named below agrees to monitor the staff member to ensure compliance with guidelines for use of the Immunization Registry.	
Supervisor Name (please print)	**Title (please print)**
Signature	**Phone**
	Fax

Registry System Administrator's Approval (PLEASE DO NOT WRITE IN THIS SPACE):

Login assigned: _____

Roles assigned: __ReadOnly __Update __Admin Other _____

Group(s) granted: _____

Signature_____ Title_____ Date___/___/_____

When completed and signed, return this form to the Registry Help Desk:

You can Fax at: 209-462-2019
OR
email to:
support@myhealthyfutures.org
Attn: Registry Help Desk

If you have questions, please call the Registry Help Desk at: 1-209-468-2292.