HEALTHeLINK™

Registration Application

Date: _____

Participation Level (Please check all that apply):

☐ Data Source ☐ Data Query and Exchange ☐ Secure Messaging

Participant Name (please print): _____

Department/Group *within* Participant (if applicable): _____

Entity Type (check one):

Individual / Sole Proprietor	☐	General Partnership	☐
Business Corporation	☐	Limited Partnership	☐
Professional Service Corporation	☐	Limited Liability Partnership	☐
Limited Liability Company	☐	Other _____	

State of Incorporation or Formation: _____

Federal Tax Identification No.: _____ Organization NPI: _____

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1. Is Participant a Covered Entity? ☐ Yes ☐ No
   (as this term is defined in the HIPAA rules)
2. Is Participant a 42 CFR Part 2 Entity? ☐ Yes ☐ No
3. Is Participant a Hybrid (45 CFR Sec 164.105)? ☐ Yes ☐ No
   * If yes, please attach a copy of your election of Hybrid Designation document.

Address for Participant:

Participant Address: _____

City/State/Zip Code: _____

Primary Business Phone: _____ Fax: _____

Number of Providers (MD, DO, NP, PA): _____ No. of Sites: _____

EMR Vendor: _____ EMR Version: _____

Primary Contact Name: _____ Title: _____

E-mail: _____ Direct Phone: _____

Alternate Contact Name: _____ Title: _____

E-mail: _____ Direct Phone: _____

Additional Sites for Participant:

Address 2: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Address 3: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Participant Type (check one):

Provider Organization	☐	Practitioner	☐
Payer Organization	☐	Health Home	☐
Accountable Care Organization	☐	Health Home Member	☐
Public Health Agency	☐	Organ Procurement Organization	☐
Independent Practice Organization	☐		

HEALTHeLINK Participants please complete this section

Authorized Contact(s):

Name: _____Phone: _____

E-mail: _____ 4-Digit PIN#: _____

Name: _____Phone: _____

E-mail: _____ 4-Digit PIN#: _____

Privacy Officer:

Name: _____

Title: _____ Phone: _____

E-mail Address: _____

Security Officer:

Name: _____

Title: _____ Phone: _____

E-mail Address: _____

HEALTHeLINK Secure Messaging Participants please complete this section

Authorized Contact(s) for organizational level email account:

Name: _____Phone: _____

E-mail: _____

The undersigned represents and attests that all facts and information are accurate, current, complete, not misleading and that:

(a) The Participant is what he / she represents it to be;

(b) The Participant will notify HEALTHeLINK of any changes to the information contained on this Form within ten (10) days of such change; and

(c) The Participant and all agents and employees thereof will at all times accurately represent itself, himself and/or herself in all communications using HEALTHeLINK/HEALTHeNET Services.

Authorized Signer: _____

Printed Name: _____

Title: _____

Date: _____

HEALTHeLINK

Responsibilities of the Authorized Contact (AC)

An "Authorized Contact" is the person(s) within your practice, facility or organization who will be responsible for the duties listed below. The AC may or may not also be the Privacy and/or Security Officer. If another individual serves in these roles, please identify them on the HEALTHeLINK Registration Application. Responsibilities include:

Communication

1. Provide HEALTHeLINK with a valid business email address to ensure delivery of important notices regarding enhancements, maintenance or other outages.

2. Communicate all changes or additions in the practice address, email address, phone or fax numbers to your HEALTHeLINK account manager immediately.

3. Communicate changes ***prior to*** major events such as mergers, sale or incorporation of your practice. Notification could be ***critical*** to preserve your current Participation Agreement (PA) and patients' consent status. Notifications after the fact may result in the termination of your current PA and loss of your current patients' consents.

Administration

4. Manage HEALTHeLINK Users within the practice/organization by: (a) Approving new Users and submitting User Account forms, (b) Changing a User's account (i.e. name changes, permissions within HEALTHELINK), (c) Reporting terminated Users ***immediately***, and (d) Ensuring ***all*** new providers added to the group are set up with HEALTHeLINK (*especially* if you have results delivery).

5. Use the ***HEALTHeLINK User Account form*** to indicate any/all user changes. When setting up a new User, choose the User's Job Category, and decide if the User needs a Secure Messaging account or access to the Prescription Monitoring Program (I-STOP) site.

6. Inform each User of HEALTHeLINK's Policies and Procedures by having the User watch the HEALTHeLINK policy video or read the HEALTHeLINK Policies and Procedures documentation. Have each User sign the *Policy Attestation* section indicating that he/she is aware of and will abide by HEALTHeLINK's Policies and Procedures. The User Account form is signed by the AC, and then faxed to your HEALTHeLINK Account Manager at 716-206-0996. **User Account forms will not be processed unless both the User and the AC have signed the form.*

7. Contact the Help Desk with any User problems including difficulties accessing HEALTHeLINK. Our local Help Desk can be reached at 1-877-895-4724.

Other

8. The AC or the Privacy officer will receive periodic Treating Relationship audits verifying there is a treating relationship between the practice and the patient that was accessed by a User in your practice. The AC or Privacy officer must review the audit and reply to HEALTHeLINK in a timely manner.

9. A practice may have more than one AC to handle off-hours password issues and manage multiple site practices. The AC will inform their HEALTHeLINK account manager of additional or new ACs.