HEALTHeLINK

Registration Application

Date: _____

Participant Name (please print): _____

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

Organization NPI: _____

Entity Type (check one):

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

Participant Type (check one):

☐Clinical Practice	☐Behavioral Health
☐Primary Care	☐Health Home Member
☐Urgent Care	☐Pharmacy
☐Public Health Agency	☐Laboratory
☐Long Term Care	☐Radiology
	☐Other _____

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1. Is Participant a Covered Entity? (as defined in the HIPAA rules)	☐ Yes	☐ No
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.

Main Address: _____

City, State, Zip Code: _____

Primary Business Phone: _____ Fax: _____

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

EMR Vendor: _____

Address 2: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Address 3: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Revised 05/09/2017

Authorized Contact/s (See attached responsibilities):

1. Name:_____ 4-Digit PIN#: _____

Phone: _____ Email:_____

2. Name:_____ 4-Digit PIN#: _____

Phone: _____ Email:_____

Privacy Officer:

Name: _____ 4-Digit PIN#: _____

Phone: _____ Email:_____

Security Officer:

Name: _____ 4-Digit PIN#: _____

Phone: _____ Email:_____

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" (AC) is the person(s) at your practice, facility, or organization who is responsible for the duties listed below. The AC may or may not also be the Privacy and/or Security Officer. If there is more than one individual, please identify them on the HEALTHeLINK Registration Application.

Responsibilities:

Communication

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

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

3. Communicate changes ***prior to*** major business transactions 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 authorized users within the practice/organization by: (a) Approving new users and submitting signed user account forms, (b) Reporting changes in a user's account (i.e. name changes, change in a user's role that may change access rights), (c) **Reporting terminated Users *in one business day*** (d) Ensuring *all* new providers added to the group are set up with HEALTHeLINK (***especially*** **if you have results delivery**), and (e) Scheduling the training of new users either with your account manger or by designating a trainer internally.

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. Ensure each HEALTHeLINK User is trained in HIPAA and HEALTHeLINK Policies and Procedures **prior to** providing access **and annually thereafter**. HEALTHeLINK Policy and Procedure training can be accomplished by having the User watch the HEALTHeLINK policy video or by reading 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.

7. Sign each User Account form and fax or email to your account manager at 716-206-0996.

8. Contact our **Help Desk at 1-877-895-4724** or your account manager with any user problems including difficulties accessing HEALTHeLINK.

Other

9. The AC or the Privacy officer will receive periodic Treating Relationship audits requiring verification 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 within three business days.

   A practice may have more than one AC. The AC will inform their account manager of additional or new ACs by submitting an updated user account form or by email.

   If applicable, the AC should ensure that all Subscribe and Notify updates are reviewed and communicated to HEALTHeLINK.