



## AUTHORIZED USER IDENTITY VERIFICATION FORM (PORTAL ACCESS ONLY)

**This form is intended for a user requesting UPHIE portal access WITHOUT a secure direct messaging address.** The purpose of this form is to provide Upper Peninsula Health Information Exchange (UPHIE) with information to add, change or terminate user access to the UPHIE portal. Once this form has been completed, have it signed by your UPHIE Registration Agent and submit it via secure email, direct messaging, fax, or USPS mail. Please contact UPHIE immediately when an employee is terminated from your organization so we can terminate their access.

- ADD New User Access
- CHANGE Existing User Access or Information (Fill out name and elements that need to be changed)
- TERMINATE User Access – Date of Access Termination: \_\_\_\_\_

|   |                |                      |
|---|----------------|----------------------|
| Date:   | Print Name:    |                      |
| Authorized User E-mail Address:   |                |                      |
| Provider Specialty or Job Function:   |                | NPI (If Applicable): |
| Practice Name:  |                |                      |
| Practice Address:   |                |                      |
| Business Phone:   | Date of Birth: | Gender:              |
| UPHIE CareAlign Home Vault and/or Sponsoring Participant User Organization: |                |                      |

I hereby represent that all above information is true and accurate and acknowledge, by my signature below, that I understand that any patient information which I see or hear is considered private and confidential. I understand that I may use or disclose protected health information only as permitted or required by the business associate contract or as required by law. I am directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by the contract or required by law. I am also directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule.

Authorized User Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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UPHIE Registration Agent: \_\_\_\_\_  
Printed Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please select if the user needs any of the following advanced access:

- Vault Admin (view users, reset passwords, lab configuration, move visits, patient lists, user reports)
- Audit Admin (view opted out patients, audit reports, user reports)