



AUTHORIZED USER IDENTITY VERIFICATION FORM (PORTAL & DIRECT MESSAGING)

This form is intended for a user requesting UPHIE portal access AND a secure direct messaging address. The purpose of this form is to provide Upper Peninsula Health Information Exchange (UPHIE) with evidence that the authorized user's identity has been verified and to add, change or terminate user access. Two forms of identification (one must be a photo ID) must be provided to an UPHIE Registration Agent, as proof of identity. Once these requirements have been completed, the UPHIE Registration Agent will submit the Identity Verification Form with ID photocopies (if required) to UPHIE 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.

Authorized User Signature: _____ Date: _____
(Sign in the Presence of Registration Agent)

I hereby certify that on this ____ day of _____ 20____, _____
Personally appeared before me as the signer and subject of the above form, who signed or attested to the same in my presence and presented the following two forms of identification as proof of his or her identity:

- | | |
|--|--|
| <ul style="list-style-type: none"> ∟ <i>Driver's License or Govt. Identification Card</i> ∟ <i>Social Security Card</i> ∟ <i>Passport</i> | <ul style="list-style-type: none"> ∟ <i>Birth Certificate</i> ∟ <i>Military ID Card</i> ∟ <i>Other: _____</i> |
|--|--|

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)