DPHHS-OM-300B
(Rev. 05/2016)

STATE OF MONTANA
Department of Public Health and Human Services

FAX completed form, within three (3) working days, to DPHHS TSD/NCB Network Security Unit at (406) 444-5924
If fax not available, please mail to: 111 N Sanders, Rm 204; Helena MT 59620 (Original form not required if faxed)

NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST

*** Denotes Required Fields**

*** LEGAL Name of Individual Requiring Access:** _____
(Please Print) *First* *MI* *Last*

Logon ID: _____ **Create Logon ID:** ☐

*** Start Date:** _____ **End Date** (if applicable)**:** _____

Employed/worked with DPHHS before: ☐ **Other Name(s) Used** *(Maiden or previous married name)* _____

*** Employer:** _____ *** Work Phone:** _____

*** Work Address:** _____ **County:** _____

_____ **Job Title:** _____

*** E-mail Address:** _____ *** Date of Birth** (to be used as unique identifier)**:** _____

*** Please list access requested here:** *imMTrax*

Choose One:

☐ Read Only w/Consent
search/view/print records

☐ Record Maintenance
+ add immunizations

☐ Vaccine Mgmt
+ vaccine lot mgmt
(VOMS 2.0)

*** Justification** ***(Give a brief description as to why access is needed):***

CONFIDENTIALITY/CONSENT STATEMENT: ***(To be read and signed by the individual requiring access.)***

I hereby certify that I am entitled to the confidential client information to which I am requesting access. I will not release the confidential information to others unless it is for purposes directly connected to the administration of the program for whose purposes it was originally provided. Further release of this information may only be done upon authorization by the client whose privacy interest is involved or it may be released to others if specifically permitted by law. I understand that a violation of this policy may subject me to disciplinary action by my employer and may result in termination of my employer's contract with DPHHS.

I have read the DPHHS Internet Policy, Information Security & Data Access Policy, and the State of Montana's Computer Use Policies (Section PL4) and I agree to comply with all terms and conditions. These policies can be found electronically at the following link. https://dphhs.mt.gov/tsd/securityforms

I agree that all network activity conducted while doing State business and being conducted with State resources is the property of the State of Montana. I understand that the State and Department reserve the right to monitor and log ***all*** network activity including E-mail and Internet use, with or without notice, and therefore, I should have no expectations of privacy in the use of these resources.

*** Signature of Employee:** _____ **Date:** _____

*****Supervisor:*** *Access for this individual is allowed for six months. I realize I will have to contact the DPHHS Network Security Unit if this employee needs access beyond the six months. I understand that it is my responsibility to inform the DPHHS Network Security Unit immediately when this employee terminates or no longer needs access.***

Printed Name of Supervisor: _____ **Phone:** _____

Signature of Supervisor: _____ **Date:** _____

This space to be completed by Data Owner(s) *(if applicable)*

Printed Name of Data Owner: _____

Data Owner Signature: _____ **Date:** _____

Printed Name of Data Owner: _____

Data Owner Signature: _____ **Date:** _____

This space to be completed by DPHHS Network Security Unit

DPHHS Security Officer: _____ **Date:** _____

imMTrax Immunization Information System (IIS)
Single User Memorandum of Agreement

imMTrax Usage

imMTrax, Montana's Immunization Information System (IIS), is a free program administered by the Montana Department of Public Health and Human Services (DPHHS) containing immunization records for participating Montanans of all ages. *imMTrax* brings together multiple immunization records from Montana healthcare providers (public and private) and parental "shot cards" to form ***one complete, electronically preserved record***. *imMTrax* assists health professionals in making appropriate immunization decisions and ensuring Montanans are immunized on time, every time.

imMTrax was created with the understanding that patient confidentiality is paramount and must be protected. *imMTrax* has several built-in security features to ensure patient confidentiality. *imMTrax* uses data encryption for all data going to and from the IIS and is compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

To apply for *imMTrax* access, a completed *Non-DPHHS Employee System/File Access Request* form and *Single User Memorandum of Agreement* is required for each individual user and must be approved by IIS staff. For questions regarding appropriate access levels for individual *imMTrax* users, contact the Montana Immunization Program at (406) 444-5580.

Some users may have direct access to school records. Per the Family Educational Rights and Privacy Act (FERPA), data from school records should ***not*** be entered into *imMTrax* ***without explicit written permission from a parent/guardian***.

As a requirement for *imMTrax* use, I accept the following conditions:

- ☑ I will safeguard my *imMTrax* access privileges and password by not permitting their use by any other person.
- ☑ I, or my employer, will notify the Montana Immunization Program if I discontinue employment, am terminated, or no longer need access to *imMTrax*. IIS staff have the authority to inactivate imMTrax user accounts that have not been accessed in over six months.
- ☑ I will not access *imMTrax* for any use outside those required to provide immunization services or activities.
- ☑ I will allow patients the option, without penalty, to have their information excluded from entry into *imMTrax* .
- ☑ I will handle information or documents obtained through imMTrax in a confidential manner and in accordance with Montana law (Uniform Health Care Information Act, MCA 50-16, Part 5) and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

imMTrax Consent

Montana has a voluntary inclusion or "opt-in" policy requiring client or guardian consent for immunizations to be accessible in *imMTrax*. Changing client consent without authorization is in violation of state confidentiality rules. When obtaining consent, the Montana Immunization Program recommends using the language in the IIS Consent Form available on the Montana Immunization Program's *imMTrax* website. The consent forms, as well as additional information and guidance can be found at: https://dphhs.mt.gov/publichealth/imMTrax/index.

As a requirement for imMTrax access, I acknowledge:

- ☑ I will ensure that consent to participate in *imMTrax* is collected and updated appropriately.
- ☑ I have read, understand and accept the terms outlined in the above Memorandum of Agreement. I understand that any violation of these provisions may result in termination of access privileges.

***Print name & Title:** _____ ***Signature:** _____

***Facility/Employer Name:** _____ ***Date:** _____