Utah Department of Health & Human Services

Healthcare Provider Facility
USIIS User Confidentiality and Security Agreement

FACILITY INFORMATION (*All* fields must be complete)		
Facility Name:	USIIS Facility (provider) ID:	
Facility Address:		
City:	State:	Zip Code:
Telephone:	Fax:	

USER INFORMATION (*All* fields must complete)	
First Name:	Office Phone:
Middle Name	Role at Facility:
Last Name:	Are you a Vaccinator? ☐ Yes ☐ No
Maiden/Other Last Names used:	Supervisor's Name:
Birth Date:	Supervisor's Email:
Work Email:	Supervisor's Phone:

The Utah Statewide Immunization Information System (USIIS) is a confidential computerized immunization information system operated and maintained by the Utah Department of Health and Human Services (DHHS). USIIS access is available only to authorized users.

USIIS is developed under the authority of the following provisions of the Utah Code: Title 26, Chapter 3, Health Statistics: Title 53A, Chapter 11, Part 3, Immunization of Students; and Utah Administrative Rule R386-800 Immunization Coordination.

As required by Section 63-46a-3(5), any person who violates any provision of the rule may be assessed a civil moneypenalty as provided in Section 26-23-6.

USER AGREEMENT	
To participate in and receive access to USIIS, I agree to the following conditions:	
1.	I will use USIIS only for the submission and access of patient or vaccination information.
2.	I will access USIIS only when needed to assure adequate immunization of a patient, to avoid unnecessary immunizations, to confirm compliance with immunization recommendations, and to control disease outbreaks.
3.	I have read and will adhere to the requirements of the USIIS Confidentiality and Security Policy.
4.	I will safeguard my user name and password against use by another individual.
5.	I will access USIIS only as an employee of the above named facility.
6.	I will not make copies of individuals' records except as authorized in the USIIS Confidentiality and Security Policy.
7.	I will only discuss information in a USIIS record as necessary for medical care of a patient and never in a manner or location that would reveal the patient's identity to unauthorized individuals.
8.	DHHS may terminate current and future access to USIIS at any time for failure to comply with these conditions.

By signing this form, I certify I have read and agree to the conditions listed above and understand I am accountablefor compliance with these conditions.	
Name (print):	
Signature:	Date:

This record is to be submitted to and kept on file with the Utah Department of Health and Human Services USIIS Program.

A copy of this completed document is considered the same as the original.

Submit via email to: usiistracking@utah.gov