Oklahoma State Health Information Network & Exchange- OKSHINE
Authorized User Agreement

OKSHINE allows health care providers to electronically access, use, transmit, and disclose patient health information. Information is encrypted and sent over a secure network.

OKSHINE Participant (Health Care Organization):	
Authorized User's Name:	**Title:**
E-Mail Address:	**Communicate/Direct Secure Messaging (DSM) Address:**

You have been designated to be an Authorized User with the following functions:

Production:

☐ Primary Provider (ex. Physician, Nurse Practitioner)
☐ Secondary Provider (ex. Nurse, Therapist, Pharmacist)
☐ Care Support (ex. Unit Clerk, Medical Assistant)
☐ Front Desk (ex. Billing Clerk, Registration Staff)
☐ Privacy Officer

Testing:

☐ Validation Testing

Participants and OKSHINE monitor the impermissible access, use or disclosure of patient health information by Authorized Users. Impermissible access, use or disclosure may result in disciplinary action and termination of this agreement and a breach could result in personal liability for damages.

As an Authorized User, you agree to the following terms and conditions.

1. I will only access, use, transmit, or disclose an individual's Protected Health Information (PHI) with whom I have a health care relationship, and the individual's written consent; for treatment, payment processing, medical emergency or other necessary business related to the Individual in the performance of my duties.
2. I agree to access, use, transmit, or disclose only the minimum necessary amount of an Individual's PHI necessary for the performance of my duties.
3. I agree to maintain the confidentiality of PHI as required under the HIPAA Rules, Federal and State Laws and Regulations, and Administrative Rules applicable to an individual's health information.
4. I agree to abide by OKSHINE policies, located at https://oklahoma.gov/ohca/okshine/resources.html
5. I acknowledge the above confidentiality requirements and OKSHINE confidentiality requirements continue beyond my employment with the Participant.
6. I acknowledge that I must participate in annual privacy and security training as a member of the Participant's workforce.

I HAVE READ AND AGREE TO COMPLY WITH THE OKSHINE AUTHORIZED USER AGREEMENT.

Authorized User's Signature:	**Date:**
Participant (Health Care Organization) Granting Authority's Signature:	**Date:**

Please return to your OKSHINE Outreach Coordinator or to OKSHINE directly via email at OKSHINE@okhca.org.