KOBLEMINNESOTA

## Authorized User Agreement

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

| Koble-MN 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 Koble-MN 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 the Koble-MN policies, located at http://koblemn.org.
5. I acknowledge the above confidentiality requirements and Koble-MN 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 KOBLE-MN AUTHORIZED USER AGREEMENT.**

| Authorized User's Signature | Date |
|---|---|
| Participant (Health Care Organization) Granting Authority's Signature | Date |

Please return to Koble-MN via email at admin@koblegroup.com.