User Security and Confidentiality Agreement

PLEASE PRINT LEGIBLY:

Clinic/School/Childcare Center / Organization Name:						
Requestor's Name:						
Organization PHYSICAL Address:						
	City:		**State:**		**Zip Code:**	

By signing this agreement, I agree to:

- Comply with the Department of Public Health and Social Services' (DPHSS) Guam Immunization Registry (GuWebIZ) Security and Confidentiality Policy and my organization's normal protocol for releasing identifiable immunization information for clients.
- Participate and provide immunization data to the GuWebIZ.
- Handle GuWebIZ identifiable information on clients in a confidential manner.
- Enter data timely and accurately.
- Not knowingly enter invalid/false data, falsify any documents or data obtained through GuWebIZ.
- Carefully and deliberately safeguard my username and password which provides access to GuWebIZ and will not permit the use of that username or password by any other person, unless expressively authorized by the DPHSS Immunization Program.
- Not furnish identifiable information or documentation obtained from GuWebIZ to individuals for personal use or to any individuals who have no duties relating to the administration, recording and reviewing of immunizations.
- Not attempt to copy the database or software used to access the GuWebIZ database without written consent from the DPHSS Immunization Program.
- Promptly report to DPHSS Immunization Program any threat to or violation of the GuWebIZ Security and Confidentiality Agreement.
- Allow the DPHSS Immunization Program and the assigned agents to audit my GuWebIZ transactions to ensure compliance with the GuWebIZ Security and Confidentiality Agreement.

- Notify DPHSS Immunization Program if you are no longer employed at this Agency/Employer, if your duties change such that you no longer require access to GuWebIZ.

The terms of the Provider Agreement, which is attached hereto are made a part hereof by reference.

I understand that GuWebIZ will not use or disclose identifiable immunization information except as necessary to protect the public health, safety, and welfare. I understand that I have no liability under the HIPPA Privacy Rule for any disclosure by GuWebIZ of immunization information submitted to GuWebIZ.

I have read, understand, and agree to abide by the GuWebIZ Security and Confidentiality Agreement and the above requirements. I understand that if I violate GuWebIZ confidentiality requirements, my access to GuWebIZ can be terminated, and I may be subject to penalties imposed by law.

I understand and agree to abide by the Guam WebIZ User Confidentiality Agreement:

PLEASE PRINT LEGIBLY

Print Name:			
Position/Title:			
Administers Vaccines?	☐ Yes ☐ No		
Business or Cell Phone:		Fax:	
*E-mail Address:			
	*Email Address is required to send your GuWebIZ Registry Account access information		
Clinic/School/Childcare Center / Organization Name:			
Signature:		Date:	

For questions and additional information, contact the Guam WebIZ Help Desk at 735-7143 or email Ms. Celena Calvo-Story, Registry Coordinator, at celena.calvo-story@dphss.guam.gov;

Department of Public Health and Social Services
Immunization Program
155 Hesler Place
Hagatna, Guam 96910

Get Immunized Guam!