NH Immunization Program
29 Hazen Drive, Concord, New Hampshire 03301
Phone: 603-271-4482 | Fax: 603-271-3850

Authorized User Agreement

New Hampshire Immunization Information System (NHIIS) is a statewide automated and electronic system that records vaccinations administered in New Hampshire. New Hampshire State law (RSA 141-C:20-f.) authorizes the Department of Health and Human Services to operate an immunization information system and allows authorized users to exchange information electronically. The NHIIS shall be a single repository of accurate, complete and current immunization records to aid, coordinate, and promote effective and cost-efficient disease prevention and control efforts. Access to the NHIIS shall be limited to authorized users who sign the user confidentiality agreement.

By requesting and receiving approval to access NHIIS Data:

1. I agree to attend all NHIIS training required for access.
2. I agree to comply with New Hampshire RSA 141-C: 20-f and New Hampshire Administrative Rule He-P 307 relating to the NHIIS.
3. I understand that NHIIS information is confidential patient information that should only be disclosed to persons authorized to receive it. I will only disclose NHIIS information as required for patient care or as authorized by law.
4. I will only access the NHIIS as necessary to update NHIIS records or obtain information to treat a patient or for other purposes allowed by NHIIS statute and administrative rule.
5. I will not knowingly include, or cause to be included, any false, inaccurate, or misleading information in the NHIIS.
6. I will not print or copy information from the NHIIS unless necessary to provide patient treatment or to print immunization records or certificates or for other purposes allowed by NHIIS regulations.
7. I agree to protect the NHIIS data as a confidential patient record and protected health information under federal and state privacy laws regardless of the form (hard copy, electronic, or verbal).
8. I understand that my NHIIS information security credentials (user name and password) must not be shared with anyone. Further, agree I will not access the NHIIS using anyone else's identification or password.
9. I will immediately notify my employer and the NH DHHS Information Security Officer at DHHSInformationSecurityOffice@dhhs.nh.gov if I know or suspect the confidentiality or security of my access, identification, and password may have been compromised.
10. I understand it is a breach of information security and privacy to use or disclose confidential information for a use not required for NHIIS related work. I will report any use or disclosure of such information *immediately* to the NH DHHS Information Security Officer at DHHSInformationSecurityOffice@dhhs.nh.gov
11. I agree to cooperate with the NH DHHS Information Security team as may be required to investigate a potential security or privacy event, incident or data breach.
12. I will not discriminate or take any adverse action against a person based on the person's NHIIS information.
13. I understand that my access to the NHIIS may be monitored by NHIIS to ensure compliance with this Agreement.
14. I understand that there are state and federal laws and regulations that ensure the confidentiality and safeguarding of Department confidential data, including personal information (PI) and protected health information (PHI).
15. I understand that misuse of the NHIIS or disclosure of NHIIS information in violation of this Agreement and/or federal and state privacy laws may also result in civil and/or criminal prosecution, penalties, or legal action.

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User Requester Full Name (*LN, FN, MI*) _____Title _____

Phone Number _____ Email _____

*Organization/Clinic name _____VFC PIN (if applicable) _____

Access Requested (Select all that apply): ☐Gives Immunizations ☐Prescribes Immunizations ☐Documentation
☐Read Only ☐ Vaccine Accountability (order/returns/inventory)

User Signature _____ Date _____

As a registered NHIIS user, I will ensure that the above employee/agent/assignee's granted access privileges adhere to the security and privacy provisions within the NHIIS User Agreement in the performance of their official duties. I will promptly notify the NHIIS Help Desk to deactivate their access privileges when an authorized user departs my practice/organization in order to maintain system security.

I acknowledge that as an NHIIS user, this user is subject to review of immunization documentation by the Department's Immunization Program or its designated agent.

Medical Director or Site Administrator Full Name (*LN, FN, MI*) _____Title _____

Medical Director or Site Administrator Signature _____Date _____

Organization/Clinic name _____