ALERT IIS
800 NE Oregon Street, Suite 370
Portland, Oregon 97232
Phone: (800)980-9431
Fax: (971)673-0276
Web: www.alertiis.org
Email: alertiis@state.or.us

Authorized Site Agreement – Clinic/Medical Site

ALERT Immunization Information System (IIS) is a statewide registry that records vaccinations administered in Oregon. State law[1] and Oregon Administrative Rules[2] cover collection and release of information in ALERT IIS. By law, information is confidential and can only be shared with authorized users, including an individual's health care provider, school, childcare facility, insurer, local health department, the individuals themselves or their parent if the person is a minor. Though information is confidential, the law allows providers to share this immunization information with ALERT IIS without consent. Information from ALERT IIS may not be used in any way to penalize an individual or organization.

As a condition of receiving immunization information from ALERT IIS as a provider (defined in ORS 433.090), users must agree to the following:

1. Only access immunization information in ALERT IIS for individuals under their care.
2. Read and abide by the ALERT IIS Confidentiality Policy.
3. Abide by all security policies and procedures, including safeguarding user name(s) and password(s) against unauthorized use.
4. Permit the ALERT IIS Director to monitor and audit users' use of the system.

Each site must also designate a "SuperUser" who must agree to the following:

1. Have the ability to activate users and assign standard user security within this site.
2. Provide oversight to ensure that users are deactivated when no longer affiliated with this site.
3. Ensure that each staff member requiring access has his or her own user name and password.

Failure to abide by this agreement may result in immediate termination, suspension or revocation of access to ALERT IIS. Misuse of ALERT IIS data will be reported to the appropriate licensing body.

Name of Clinic/Medical Site: _____

Parent Organization (if any): _____ VFC Pin (if receiving state vaccine): _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Clinic Type (check all that apply): ❑ Private Clinic ❑ Pharmacy ❑ Family Planning Clinic ❑ State Agency (e.g., DOC) ❑ Local Health Dept. ❑ SBHC ❑ FQHC/RHC/IHS ❑ Delegate ❑ Satellite ❑ Hospital ❑ Other: _____

To which age groups do you provide immunizations onsite? ❑ 0-6 yrs ❑ 7-18 yrs ❑ 19+ yrs ❑ We do not immunize

Planned Data Submission Method: ❑ Electronic Files ❑ Web Entry/User Interface ❑ Queries Only ❑ Other: _____

Primary Contact/SuperUser First Name: _____ Middle Initial: ___ Last Name: _____

Title: _____ Phone: _____ Email: _____

Clinic's Authorized Representative (e.g., Managing Physician, CEO): _____

Title: _____ Phone: _____ Email: _____

This form must be signed by both the clinic's SuperUser and Authorized Representative:

Signature of SuperUser: _____ *Date:* _____

Signature of Authorized Representative: _____ *Date:* _____

For Office Use Only

Date Received: _____	Date Entered: _____	Code(s) Assigned: _____	Initials: _____

[1]ORS 433.090 to ORS 433.102
[2]OAR 333-049-0100 to OAR 333-049-0130