TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347 • Austin, Texas 78714-9347•1-888-963-7111

REMOTE USER SECURITY RIGHTS AND CONFIDENTIALITY FORM

One DSHS Laboratory Remote User Security Rights and Confidentiality Form must be completed and submitted for each person to be set up for remote access. The requesting Facility Administrator will sign and date this form and fax, mail, or scan the form and e-mail it to DSHS Laboratory.
Fax: 512-776-7157, Attn: Remote Lab Support, L357.1   E-mail: **remotelabsupport@dshs.state.tx.us**

Section 1: Applicant Contact Information (Please fill out all *Required* fields)

Applicant
NAME: Last _____   First _____   MI _____
Required   *Required*

E-mail: _____   Phone #: _____
Required   *Required*

Facility Name: _____   Fax #: _____
Required – Must match Facility Name as on Facility Security Agreement   *Required- If fax machine is secured*

Facility 8-digit Submitter ID: _____   Facility 9-digit TPI: _____
Required – Newborn or Microbiology   *Required – Clinical Chemistry*

☐ Newborn Screening ☐ Clinical Chemistry ☐ Microbiology
Facility City and Zip Code: _____ , _____
Required – City   *Required – Zip*   *Types of Test Result(s) as on Facility Security Agreement*

Section 2: Clinical Chemistry Requests Only. Please list all ordering providers submitting tests for the Facility. Attach additional page if needed.

Name and Credentials (MD, PA, etc):	9-digit TPI:	10-digit provider NPI:
_____	_____	_____

Section 3: Confidentiality Form

The Department of State Health Services (DSHS) authorizes _____ (*Facility Name*) to access and use the services of
☐ **Newborn Screening** ☐ **Clinical Chemistry** ☐ **Microbiology**. Certain designated facilities (laboratories, hospitals, healthcare providers, etc.) have a legitimate need to access this system in order to review, record, and/or edit data. The facility's authorized personnel will be provided access to information and data that is sensitive, confidential, protected health information, or is otherwise protected from disclosure to unauthorized individuals. To ensure the integrity, security and confidentiality of DSHS information and data, all individuals who obtain access to DSHS information resources agree to treat all information and data as highly sensitive, confidential and protected from disclosure. Except as authorized by state and federal law, (including, but not limited to, the Health Insurance Portability and Accountability Act), publication, disclosure or discussion of any information or data observed during the use of this service is strictly prohibited.

> **Each person who will have access to DSHS Information Resources is required to sign a copy of this agreement**.

I _____ a representative of _____ (*Facility Name*) am using this service on behalf of the named facility for the limited purpose of the agreement between DSHS and the facility. I understand and agree to the limited terms and conditions of this agreement.

I also understand that DSHS is required by law to protect the confidentiality and security of its network and the data and information maintained by the department from outside disclosure, and that even an inadvertent disclosure could result in serious security or confidentiality breaches resulting in the loss, destruction or disclosure of sensitive and confidential information maintained by the department. I understand that I am also responsible for the confidentiality of the system's configuration and network architecture. I further understand that my breach of this agreement could result in violation of state and federal laws, under which civil and criminal penalties could be assessed for each violation.

I agree that I will not disclose nor release my username and password to anyone at any time. In the event my username and password have been compromised, I will immediately contact DSHS so that my account can be inactivated immediately. A new account will be issued to me with a new username and password.

State and federal law provides civil and/or criminal penalties for use or disclosure beyond the limited purpose of the performance of this service.

_____   _____
Applicant's Signature   **Date**

_____   _____
Facility Administrator's Signature   **Date**

☐ Terminating Web User Account Access, Facility Administrator Signature and Date: _____

Security Rights and Confidentiality Form Instructions

Fill out each section for the remote user. Please submit one form per remote user.

Section 1: Applicant Contact Information

- **Last name, First Name, Middle Initial** – The user that will be setup for web application use or as a role within the application. Must be the information for the user signing the Applicant's Signature field of the Confidentiality Form.
- **E-mail** – DSHS will include your e-mail in the web application – Remote Users distribution list to inform you about any important updates or as part of troubleshooting.
- **Phone #** – Of the clinic that will submit tests remotely or print laboratory reports remotely.
- **Facility Name** – Name of clinic that will submit tests remotely or print reports remotely; Facility Name as on Facility Security Agreement.
- **Fax #** – Of the clinic that will submit tests remotely or print laboratory reports remotely, fax machine must be in a secured location.
- **8-digit Submitter ID** – DSHS assigned clinic identification number required for Newborn Screening and Microbiology tests. Can be found next to submitter name on result reports.
- **9-digit TPI** – TMHP assigned clinic Medicaid Texas Provider Identifier number required for submission of Clinical Chemistry tests. Can be found next to submitter name on result reports.
- **Facility City and Zip Code** – City and Zip Code of clinic or Facility.

Section 2: Clinical Chemistry Only. Please list all ordering providers you will be submitting tests for. Attach additional page if needed.
- **Ordering Provider** – A physician or qualified non-physician practioner licensed by the State to order laboratory services provided by the DSHS laboratories.

Section 3: Confidentiality Form

- **Facility Name** – Name of clinic that will submit tests remotely or print reports remotely; Facility Name as on Facility Security Agreement.
- **Laboratory Services –** Newborn Screening, Clinical Chemistry and/or Microbiology
  - **Newborn Screening** performs Newborn Screening tests
  - **Clinical Chemistry** performs tests such as Lead testing, Total Hemoglobin, Hg Electrophoresis, Glucose, etc.
  - **Microbiology** performs tests such as TB, HIV / STD, Rabies, Rubella, Serology, Molecular, Parasite, Flu, Virology, etc
- **Applicant's Signature** – The person that has his/her information filled out in Section 1.
- **Facility Administrator –** The point of contact at the Facility that can authorize web user setup, web user termination and maintain current Facility and provider information. This is usually the office manager.
- **Terminating Web User Account Access** – when access is no longer needed by the web user. The Facility Administrator is to check-off the check box, sign and date the form and fax to (512) 776-7157.

Please submit the completed form to DSHS Remote Laboratory Support:
- **Fax** – Attention: Remote Lab Support L357.1, (512) 776-7157
- **Emai**l – remotelabsupport@dshs.state.tx.us

For further assistance or additional clarification, please e-mail remotelabsupport@dshs.state.tx.us