GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

GuWebIZ Provider Agreement

PRINT INFO:

Provider/Agency Name:	
Business Name (if different from above):	
Physical Address of Provider/Agency:	
Mailing Address (if different from Physical Address):	
Business Phone Number:	Fax Number:
Provider Number (NPI), if applicable:	

The Guam Immunization Information System (IIS), also known as GuWebIZ, is the repository of patient and immunization data on children, adolescents, and adults from birth to death. GuWebIZ has the support and data sharing capability of patients' immunization records for Guam and participating islands.

As a condition for participation or continued participation as a GuWebIZ provider, I, the authorized provider and authorized users will comply with the following terms and conditions;

Participation in the implementation and use of a computerized IIS to ensure the timeliness, validity, accuracy, completeness, and up-to-date immunization histories and personal demographic data of residents living in Guam and participating islands.

Provide the Department of Public Health and Social Services (DPHSS), Immunization Program with immunization data, which includes personal identifying information, to provide for disaster recovery back up and support state level analysis effort.

DPHSS, Immunization Program shall:

- Provide ready access to the database to participating provider(s) and/or agency;
- Grant access to patient records identified under their care;
- To be able to create patient records with adequate information to specifically identify the patient;

- Maintain standardized lists of vaccine types, manufacturer, lot numbers, immunization schedules, and (optional) vaccine inventories as a service to participating local providers, determine recommended immunizations for patients based on their immunization histories and approved vaccine schedule;
- Control access to and updates of patients' records via an established protocol;
- Provide a written Operational Recovery Plan also known as a Disaster Recovery Plan (The goal of the Operational Recovery Plan shall be the ability to recreate the immunization information system and all of its components with minimal loss of data after a disaster, in order to restore all essential registry functions);
- Monitor access and detect intrusions to GuWebIZ and have an established protocol for responding to such attempts. Employ current virus detection software for the purpose of detecting and removing computer viruses from registry components.
- Define reasonable procedures for the patient or parent/legal guardian to inspect the patient's record and to indicate errors.

The Provider/Agency shall agree:

- To access the GuWebIZ only through approved IIS access procedures;
- That those authorized users who access GuWebIZ sign a User Security and Confidentiality Agreement provided by the Immunization Program. A copy of the agreement shall be maintained by the authorized provider and the original agreement forwarded to Immunization Program;
- Not to disclose GuWebIZ access codes or protocols to unauthorized persons. Ensure that only authorized users have access to immunization data and services for their patients/clients, any lapse in enforcing security by the provider may result in the provider being terminated from participation in GuWebIZ;
- To use information obtained from GuWebIZ only to provide immunization services appropriate for their patients/clients/students;
- To the maintenance and servicing of any Immunization Program issued computer equipment and peripherals, to include upgrade/update anti-virus to ensure protection of data. Provider is responsible for the proper use of computer equipment and peripherals, agree to inform the program of any damage or loss of equipment due to any negligence in care and maintenance of equipment or malicious acts of theft or vandalism;
- Inform patient or parent/legal guardian of their right to choose or refuse inclusion of their information to GuWebIZ.
    - Ensure patient or parent/legal guardian complete a consent form with signature and date, the original consent form shall be maintained by the Provider/Agency and a copy shall be provided to the patient or parent/legal guardian or providers medical record screening process;
    - Parent/legal guardian or individual may opt-out of the registry for themselves or their child/ward by submitting a written request to DPHSS for record removal.
- Maintain the confidentiality of patients' information obtained from GuWebIZ as required of medical records. A copy of the Provider/Agency's confidentiality policy shall be forwarded to the program;
- Disclose in writing and verbally to patient or parent/legal guardian that information

from the patient's records will be shared with other providers, health plans, schools, daycare providers, Women, Infants, and Children (WIC) Program, and local health departments as necessary to provide immunization services and that patient or parent/legal guardian has the right to refuse to have information shared.
    - Document with patient or parent/legal guardian signature and date of any refusal to participate. Inform and document with patient or parent/legal guardian signature and date of their right to refuse to receive immunization reminder or recall notices. Provider/Agency shall maintain the original document and provide copy to patient or parent/legal guardian.
- To GuWebIZ training for standard confidentiality practices for authorized users handling confidential data.
- Data should not be downloaded on any removable storage media; data on workstations or backup drives shall be rendered unrecoverable before discarding or disposing of the storage media; any hard copy produced by a registry that contains confidential data will be shredded before disposal.
- Provider/Agency agrees to report any breach of security or confidentiality in writing which has occurred to the Immunization Program immediately upon discovery.

Disclosure of Registry Information

Unless there is a refusal to permit record sharing, the Provider/Agency may disclose the information below to GuWebIZ and the Immunization Program, which in turn, may disclose the information to schools, childcare centers, health plans, and health care providers taking care of the patient, upon request for information pertaining to a specific person.

The information that may be disclosed by health care providers to GuWebIZ and the Immunization Program:

1. Name of the patient and names of the patient's parents or guardians;
2. Date of birth of the patient;
3. Current address and telephone number of the patient and the patient's parents or legal guardians
4. Patient's gender;
5. Patient's place of birth;
6. Manufacturer and lot number of each immunization received;
7. Types and dates of immunizations received by the patient;
8. Adverse reaction to immunizations received;
9. Other non-medical information necessary to establish the patient's unique identity and record; and
10. Any other elements authorized by law.

Information will not be shared with other providers or agencies if the patient or parent/legal guardian refuses to have the information shared.

Information will be shared with a querying provider or agency only if sufficient personal information is provided to identify the patient;

The patient or parent/legal guardian has the right to examine any shared immunization-related information and to indicate error in GuWebIZ to DPHSS/IMM, which, upon notification by acceptable means, will correct the error or note disagreement about whether an error exists.

In general, any disclosure of patient information from GuWebIZ shall be made only in the best interests of the patient, and any person or entity to which information is disclosed or re-disclosed will be subject to the same conditions of confidentiality imposed.

Termination

This Provider Agreement may be terminated by either party within thirty (30) days of written notice to terminate the agreement.

This Provider Agreement will be terminated immediately by the Immunization Program if any negligence, breach of Health Insurance Portability and Accountability Act (HIPAA) and/or unauthorized release of Protected Health Information.

Responsibility

Provider/Agency acknowledges that the Immunization Program is not responsible for the accuracy of the data which they receive. In no event shall DPHSS, Immunization Program be liable for special, indirect, and/or consequential damages.

Provider/Agency hereby waives any claim and recourse against DPHSS, Immunization Program for such damages.

Provider/Agency shall strive to provide complete, valid, accurate and timely data.

Provider/Agency acknowledges that all equipment (hardware and/or software) provided by the program is contingent upon the provider staying with the registry and/or upon availability of funds.

Right to Audit

10 GCA § 3326. Immunization Audit.

Annually, the Director shall conduct an immunization audit. Sample audits shall be conducted on public health clinic records, private clinic records and private physicians' records to determine if:

(a) One (1) consolidated immunization record is posted on the inside front cover of the patient's medical record if the patient is under the age of eighteen (18); and

(b) If the record of any child found to be deficient in immunizations indicates:

1) That progress towards immunization is being made;
2) A record of scheduled return appointment for the child; or
3) A reason for the lack of immunization.

10 GCA § 3327 Same: Confidentiality.

The immunization audit shall be done by the Director who may delegate his duty. The Director shall be responsible for assuring that the confidentiality of individual patient records is preserved. The Department shall be responsible for compiling a statistical report of the audit.

The Immunization Program has the right to audit compliance with the confidentiality protection in this agreement and to make recommendations for improvement.

This agreement constitutes the entire agreement with regard to the subject of this agreement. No amendment or modification of any of the provisions of this agreement will be valid unless set forth in a written instruction signed by both parties.

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The Provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of Territory of Guam that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person and that I am eligible to sign this agreement.

Print name of Authorized Provider or Representative signing the Provider Agreement		
Title of Authorized Provider or Representative signing the Provider Agreement		
Phone Number	**Email Address**	**Date Signed**
Signature of Authorized Provider or Representative signing the Provider Agreement		