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**ODHIN User Agreement Form**

Use of the On Demand Hospital Information Network (ODHIN) and all data/analytics contained within is governed by the Business Associate Agreement (BAA) your facility has with the Alaska Hospital & Healthcare Association (AHHA). Under this agreement, data in ODHIN cannot be shared publicly without prior approval from AHHA. For a copy of the BAA, please contact [jmonk@alaskahha.org](file:///G:\Shared%20drives\Data%20Initiatives\OHDIN%20-%20Colorado%20collaboration\OHDIN%20Access\jmonk@alaskahha.org).

Any patient data accessed in ODHIN is also governed by HIPAA, and all necessary precautions should be taken to guard ODHIN accounts and any data/analytics downloaded from ODHIN. Carefully consider who can access any data that is shared internally, especially in meetings that may be publicly discoverable. Do not share data or analytics downloaded from ODHIN with individuals in your organization who would not otherwise have permission to access PHI or sensitive data. Follow HIPAA guidelines when storing data, screenshots or other analytics downloaded from ODHIN.

A reminder that any data or analytics downloaded from ODHIN may not be directly referenced in any way that disparages or portrays other AHHA members in a negative light. For example, you may not run a newspaper ad using the ODHIN avoidable care data to show your facility has fewer avoidable readmissions than your competitor.

You may not share your username or password or allow someone else to access ODHIN through your sign-in. Only sign into the Power BI service over a secure internet connection (not a public, unsecured connection). If you think that your password has been compromised, please reset it and contact AHHA at soon as possible. We audit site usage; accounts inactive for six months will be deactivated. If you no longer need access to ODHIN, please inform jmonk@alaskahha.org so we can close your account.

By signing this form electronically, you acknowledge that you have read, understood and will follow these usage rules and all applicable HIPAA guidelines, in addition to any internal regulations your facility may have governing the use of sensitive data. Failure to follow these rules will be grounds for terminating your access to ODHIN.

**NEW USER INFORMATION**

* User First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hospital(s) or System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you need access to ALL hospitals in a System, list the System only. If you need access to only select hospitals within a system, please contact us* *to submit a separate list of hospitals.*

* Role/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cell Phone # (For MFA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Supervisor Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Supervisor Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Supervisor Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Starred fields DO NOT need to be completed by C Suite Users. **If User is in the C-Suite, please mark starred fields with ‘NA’**

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**ODHIN Approval Form**

This portion of the form must be completed by a supervisor with authority to grant access to sensitive hospital and clinical data. Please ensure that you complete ALL parts of the form, sign and scan to [jmonk@alaskahha.org](mailto:jmonk@alaskahha.org)

Data Usage -Use of ODHIN and all data/analytics contained within is governed by the Business Associate Agreement (BAA) your facility has with the Alaska Hospital & Healthcare Association (AHHA). Under this agreement, data in ODHIN cannot be shared publicly without prior approval from AHHA. For a copy of this agreement, contact [jmonk@alaskahha.org](mailto:jmonk@alaskahha.org). Please be advised that any patient data accessed in ODHIN is also governed by HIPAA, and all necessary precautions should be taken to guard ODHIN accounts and any data or analytics downloaded from ODHIN. Carefully consider who can access any data that is shared internally, including in meetings that may be discoverable by the public.

**APPROVAL INFORMATION**

Access Control - Each login may only be used by the individual to whom it was assigned. Any sharing of login information is grounds for termination of access. By granting the individual above access to ODHIN, **you or your representative are also responsible for informing AHHA if the individual departs your facility or otherwise should no longer have access to ODHIN.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, approve \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to have access to

**SUPERVISOR** FIRST/LAST NAME **USERS** FIRST/LAST NAME ODHIN and, if applicable, the additional level of data indicated above.

I will notify AHHA if his/her access should be terminated. By signing I also confirm that I have the authority to grant this user access to the selected data and facilities.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return signed form to** [jmonk@alaskahha.org](mailto:jmonk@alaskahha.org) or [dlowenthal@alaskahha.org](mailto:dlowenthal@alaskahha.org)