# PROVIDER DELEGATION OF IRIS USE TO THIRD PARTY
## Berrien Mental Health Authority / Riverwood Center

***NOTICE:** For security and audit compliance, access to the EHR (IRIS) will only be granted to individually assigned email addresses; requests using share, group, or mailing list addresses will be denied without exception.

**RIVERWOOD PROVIDER NAME:** _____

**THIRD PARTY USER NAME:**

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT _____ (THE PROVIDER) HAS REQUESTED ACCESS TO THE IRIS SYSTEM FOR _____ (THIRD PARTY USER) AS THEY REQUIRE ACCESS TO PERFORM BUSINESS ASSOCIATE FUNCTIONS ON BEHALF OF THE PROVIDER.

_____ DATE

_____ AUTHORIZED PROVIDER SIGNATURE

_____ PRINTED NAME & TITLE

_____ (THE THIRD-PARTY USER) AGREES TO ONLY ACCESS INFORMATION IN IRIS CONSISTENT WITH THE BUSINESS ASSOCIATE AGREEMENT (BAA) WITH PROVIDER AND HIPAA REGULATIONS.

_____ DATE

_____ AUTHORIZED THIRD PARTY USER SIGNATURE

_____ PRINTED NAME & TITLE

I AM REQUESTING BMHA GRANT OR DELETE ACCESS TO THE FOLLOWING THIRD PARTY STAFF IN IRIS:

| THIRD PARTY USER NAME: | USER TITLE: | USER EMAIL ADDRESS: | ADD | DELETE |
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| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

I HEREBY AGREE TO IMMEDIATELY NOTIFY externalclaims@riverwoodcenter.org AT BMHA IF THE INDIVIDUAL ENDS EMPLOYMENT OR IF THEY TRANSITION TO A POSITION THAT WOULD NO LONGER REQUIRE ACCESS TO THE BMHA CLAIMS SYSTEM FOR THEIR JOB FUNCTIONS. I FURTHER AGREE THAT ALL USER-NAMES AND PASSWORDS MUST BE USED ONLY BY THE PERSON IT HAS BEEN ASSIGNED, VIOLATION OF THIS PROVISION MAY RESULT IN SANCTIONS.

_____ _____

DATE AUTHORIZED THIRD PARTY USER SIGNATURE

_____

PRINTED NAME & TITLE

PLEASE FORWARD COMPLETED FORMS TO: Email: externalclaims@riverwoodcenter.org or FAX: 269.934.3388.

***PLEASE NOTE THAT IF THE FORM IS NOT LEGIBLE, IT WILL BE RETURNED. ***