



IRIS USER REQUEST FORM FOR THIRD PARTIES

Berrien Mental Health Authority / Riverwood Center

BMHA Contracted Provider (Name): _____ is requesting access for its Third-Party User (Name): _____ to perform Business Associate Functions on behalf of the Provider. A valid Business Associate Agreement (BAA) between the above-named Provider and Third-Party User has been entered into and a copy has been presented to BMHA.

BMHA Contractual Provider Acknowledgement:

By signing this form, I acknowledge that the Third-Party User will have access to private information, including rates charged, money received and consumers served with my full permission in Riverwood Center's electronic health record and claims system, IRIS.

Authorized Provider Signature: _____ Date: _____

Printed Name: _____ Title: _____

Third-Party User Acknowledgement:

By signing this form, I acknowledge that as a Third-Party User of IRIS, I agree to only access information in IRIS consistent with the Business Associate Agreement (BAA) with RW Contracted Provider and HIPAA regulations.

Authorized Provider Signature: _____ Date: _____

Printed Name: _____ Title: _____

****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.

Granting/Removing Access to Third-Parties in IRIS:

As the authorized Agent of the Provider, I am requesting BMHA to make the following change to the list of permissive users to enter/view claims and reports in IRIS:

Third Party User First & Last Name	Title	Email Address
☐ Add	☐ Delete	☐ Needs 837 permission

Third Party User First & Last Name	Title	Email Address
☐ Add	☐ Delete	☐ Needs 837 permission

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 not longer require access to BMHA's electronic health record and claims system for their job function(s). I further agree that all usernames and passwords must be used only by the person it has been assigned to, violation of this provision may result in sanctions.

Authorized Provider Signature: _____ Date: _____

Printed Name: _____ Title: _____

Completed forms and copies of executed Business Associate Agreements between the Provider and Third Party must be submitted to: externalclaims@riverwoodcenter.org or fax: 269-934-3388 before access will be granted.

Please note: Users must log in at least once every 30 days to avoid being deactivated. If you need to be re-activated, contact the email address above.