



# COLORADO

Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

## Colorado Immunization Information System Participating Clinic Letter of Agreement

Date: \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip Code: \_\_\_\_\_

Pursuant to C.R.S. §25-4-2401 et seq., the Colorado Department of Public Health and Environment (CDPHE) operates a web-based state immunization registry, the Colorado Immunization Information System (CIIS). The CIIS mission is to establish and maintain a population-based, confidential, fully functional, and sustainable immunization information system that facilitates the timely and complete immunization for all Coloradans to prevent disease and reduce health care costs to individuals and the State.

The term "Participating Clinic" refers to the entity identified at the top of this Letter of Agreement (LOA). By returning a signed copy of this LOA you acknowledge and confirm that: 1) you are authorized to sign this LOA on behalf of the Participating Clinic, 2) the Participating Clinic is an entity authorized to disclose information to and receive information from CIIS under the Immunization Registry Act, 3) the Participating Clinic will only permit access to the disclosed information for clinical, quality improvement and school entry law purposes, 4) if entering data manually into the CIIS web application, the Participating Clinic must enter their clients' non-historical immunization services into CIIS within 30 days of the respective vaccine administration dates, or if submitting data electronically to CIIS, the Participating Clinic must send their clients' non-historical immunization services to CIIS within 7 days of the respective vaccine administration dates, 5) the Participating Clinic will treat all information in CIIS as confidential, 6) if the Participating Clinic discloses information to CIIS, it has provided notice to individuals, parents or guardians as required by C.R.S. § 25-4-2403(7) stating that the individual, parent or guardian can choose to have their (or their child's) immunization information excluded from CIIS, 7) the Participating Clinic is responsible for the provision and maintenance of any necessary computer hardware, network connections, telecommunication lines, internet access and data uploads/downloads from existing electronic health record systems which may be necessary for the clinic's participation in CIIS, and 8) the Participating Clinic is responsible for ensuring that all persons or entities (including providers, staff, contractors and agents) who access information through CIIS are authorized to receive access to such information and will comply with all applicable laws, regulations and CIIS policies, including the CIIS Confidentiality Policy and the CIIS Security Policy. The CIIS Confidentiality Policy and CIIS Security Policy are reviewed and potentially revised at least annually. You may obtain a copy of current policies at [www.ColoradoIIS.com](http://www.ColoradoIIS.com).

CIIS agrees to: 1) provide and maintain a secure and functional immunization registry, 2) provide ongoing technical assistance and support to facilitate access to and use of the system, and 3) notify the Participating Clinic of any potentially incorrect information in CIIS attributable to one of its patients so that it may promptly correct the information, if necessary. We also ask that the Participating Clinic perform regular quality assurance audits of information concerning its patients to ensure the continued integrity of the system.

To terminate your access to and participation in the CIIS program, please email us at [CDPHE.CIIS@state.co.us](mailto:CDPHE.CIIS@state.co.us) at least 30 days prior to your planned termination date. Please note that CDPHE will not delete any data sent to CIIS by any Participating Clinic prior to a clinic's termination of participation.

By: \_\_\_\_\_  
Participating Clinic Representative Printed Name

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

By: \_\_\_\_\_  
Participating Clinic Representative Signature

By: \_\_\_\_\_  
Heather Roth, MA  
Colorado Immunization Information System Program Manager

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

October 2015





			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

**\*How does your clinic intend to report data to CIIS?**

- Manually enter data into CIIS web application       Electronically report data to CIIS through interface from EHR

**IF PLANNING TO REPORT DATA ELECTRONICALLY TO CIIS, PLEASE COMPLETE ALL FIELDS BELOW.**

**IT/TECHNICAL SUPPORT**

Company Name	Contact Person	Phone Number	Email Address	Role? (e.g., Programming, FTP Uploads, Data Quality, etc.)

**DATA VALIDATION**

As part of creating an interface with CIIS, you will need to identify someone who can pull 30 patient records so that we can perform a data validation check. This is generally someone within the clinic. Please identify this person below.

Contact Person	Title	Phone Number	Email Address

**ELECTRONIC HEALTH RECORD (EHR) SYSTEM DETAILS**

<b>Please PRINT clearly.</b>	
EHR Vendor Name	
EHR Product Name	
EHR Product Version	
Date of clinic's last EHR upgrade	
EHR Contact Person <b>and</b> Title	
Phone Number	
Email Address	

**- CIIS PROGRAM USE ONLY -**

Clinic Code: _____	Entered into production by: _____	Date: _____
	Entered into CRC by: _____	Date: _____



# COLORADO IMMUNIZATION INFORMATION SYSTEM (CIIS) CLINIC ADMINISTRATOR FORM



**Instructions:** Use this form to designate a CIIS Clinic Administrator for your office. The CIIS Clinic Administrator responsibilities are described below. Please complete the form and either fax it to 303.758.3640 or email it to us at [CDPHE.CIIS@state.co.us](mailto:CDPHE.CIIS@state.co.us). **NOTE: All fields marked with \* are required.** Questions? Call us toll-free at 1.888.611.9918, option #1 or 303.692.2437, option #2.

\*Date \_\_\_\_\_

**\*Why are you completing this form? (Check all that apply)**

- I want to **update** my existing clinic profile in CIIS with new information.
- I want to **create** a clinic profile in CIIS for my office. *(For clinics new to CIIS)*
- I want to **submit** this form as part of Meaningful Use immunization reporting requirements.

**CLINIC INFORMATION – Please PRINT clearly.**

*Clinic Name	
*Clinic Street Address (include Suite #)	
*City, State and Zip Code	
*Clinic Phone Number	
*Clinic Fax Number	
*Clinic County	
Website Address (if applicable)	

**CIIS CLINIC ADMINISTRATOR INFORMATION – Please PRINT clearly.**

*CIIS Clinic Administrator Name	
*Position/Title	
*Clinic Admin Direct Phone Number	
*Clinic Admin Direct Fax Number	
*Clinic Admin Email Address	
*Hours Available	

**\*What is the best way to contact you?**     Phone                       Email

Are you replacing the previous CIIS Clinic Administrator for your office?     Yes     No

**\*CIIS Clinic Administrator Responsibilities Agreement**

I understand that by accepting the role of CIIS Clinic Administrator, I am:

- Required to approve the creation, deletion or inactivation of any user accounts for my clinic
- The sole authority for account approval – no account creation will occur without my approval and signature
- The point of contact for account verifications, system alerts and policy changes
- Responsible for ensuring that my staff:
  - Comply with all applicable laws, regulations and CIIS policies
  - Access immunization information only to provide care to a patient or to perform quality assurance
  - Treat all information in CIIS as confidential
  - Not release or re-disclose any information in CIIS to any unauthorized person
  - Not allow another person to use their account information to access CIIS
  - Receive training on the appropriate use of CIIS
- Responsible for notifying CIIS when staff members no longer work at the clinic and require account inactivation within one week of staff members leaving the clinic.
- Responsible for notifying CIIS at least one week in advance that I am no longer able to perform these tasks to allow for the transition to a new CIIS Clinic Administrator.

**\* CIIS Clinic Administrator Signature:** \_\_\_\_\_

- CIIS PROGRAM USE ONLY -		
Clinic Code: _____	Entered into Production by: _____ Entered into CRC by: _____	Date: _____ Date: _____