# WISCONSIN IMMUNIZATION REGISTRY
# USER AGREEMENT

| Organization or School/District Name |
|---|
| Organization or School/District Address (Street, City, State and Zip Code) |

| User Name | Title |
|---|---|
| Telephone Number | Email Address |
| Address (Street, City, State and Zip Code) | |

By signing this agreement, I agree to:

- Comply with the Wisconsin Immunization Registry Organization Security and Confidentiality Agreement (F-42008) and my organization or school/district protocol(s) pertaining to the release of identifying immunization information of clients.
- Participate and provide immunization data to the Wisconsin Immunization Registry (hereinafter "WIR").
- Input and utilize WIR identifiable health and personal information on clients in a timely, accurate, and confidential manner.
- Use the WIR to access information and generate documentation only as necessary to properly conduct the administration and management of immunization services.
- Carefully and deliberately safeguard my user ID and password for the WIR and not permit the use of that information by any other person, unless expressly authorized by WIR staff.
- Not provide identifying information or documentation obtained from the WIR to individuals for personal use nor any individuals who do not have duties relating to the administration, recording, or reviewing of immunizations.
- Not contact a person whose immunization record is part of WIR except on official business or in the course of official duties without proper authorization from WIR staff.
- Not examine or read any records or immunization data regarding, not limited to, family, friends, public figures, and celebrities; except on a need to know basis.
- Not attempt to copy the WIR database or software used to access the WIR.
- Promptly report to WIR staff any threat to or violation of the WIR Organization Security and Confidentiality Agreement (F-42008).

I have read, understand, and agree to abide by the WIR Organization Security and Confidentiality Agreement and the above requirements. I understand the Wisconsin Department of Health Services reserves the right to audit, monitor, record and/or disclose all transactions and data sent over this system in a manner consistent with State and Federal law. Any illegal, unauthorized use or modification of WIR and its contents is prohibited and may be subject to civil or criminal prosecution under state and/or federal laws.

I consent to the monitoring of my access and use of WIR. I understand that, if I violate WIR confidentiality requirements, my access to WIR data can be terminated and I may be subject to penalties imposed by law. In addition, my supervisor and owner of the provider practice will be notified of the breach of confidentiality and asked to take action appropriate to their organization.

**SIGNATURE** – User

Date Signed

Print Name and Title of User

**SIGNATURE** – Site Administrator or Principal/Superintendent

Date Signed

Print Name and Title of Site Administrator or Principal/Superintendent