

Admin Username Assigned:

Immunization Registry Information System (IRIS) Authorized Site Agreement - Organization

IRIS – Immunization Program Lucas State Office Bldg, 5th Floor 321 E 12th Street Des Moines, IA 50319-0075 Phone: (800)374-3958

Fax: (800)831-6292

www.idph.state.ia.us/ImmTB/Immunization.aspx

Please complete and send to IRIS staff.

Name of Site/Organization:	VFC PIN:
Physical Address:	City, State, Zip
Mailing Address:	City, State, Zip
Phone: Fax:	Email:
Primary Contact/Admin User Name:	
	Email:
	nysician, Clinic Manager, CEO):
	Email:
	Health □RHC/FQHC □Hospital □Pharmacy □Long Term Care Center of Corrections □ State agency □Head Start □Other:
Planned use of IRIS: □Web Entry/User Inte	face □Electronic Files □ View Only □ Other:
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In order to participate in IRIS, this Organizat 1. Only access immunization informati 2. Abide by the IRIS Confidentiality Polunauthorized use. Access records o 3. Will not impose a charge or fee to tl 4. Assure Individual User Agreements 5. Designate an "Admin User" who wil a. Activate users and assign sta b. Maintain signed Individual User d. Ensure that Individual User the IRIS Confidentiality Police	on in IRIS for individuals to whom the organization provides services. cy, including safeguarding user name(s) and password(s) against ally under the user's own name and password. e patient for use of IRIS or for any information obtained from IRIS.
	t in immediate termination, suspension or revocation of access to IRIS and By signing below, I agree to the above conditions and will abide in
Signature of Authorized Representative:	Date:
	Date:
For Office Use Only Date Received: Date Entere	d: IRIS Clinic # Assigned: Initials:

Date Activated: