MYAVATAR CONTRACTED PROVIDER USER ACCESS REQUEST AND CONFIDENTIALITY AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
SFN 943 (1-2025)

Clear Fields

Contracted Employee Name (Last, Middle Initial, First)	Access Begin Date
Contracted Employee Work Email	
Request Type (check all that apply) ☐ Direct Care Staff ☐ Nursing Staff ☐ Supervisor/Administrator	
Contracted Employee Credentials (check all that apply) ☐ DCA ☐ MHT ☐ MAI ☐ MAII ☐ CNA ☐ NA ☐ RN ☐ Other (specify):	
Have you previously had access to the myAvatar solution? (i.e. due to former or current employment with another agency) ☐ Yes ☐ No	

Contracted Agency Name	
Region	Telephone Number

I acknowledge that I will have access to information that is confidential under state and federal confidentiality laws including information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR parts 160 and 164 (HIPAA Privacy, Security, Breach Notification, and Enforcement Rules) and 42 C.F.R. Part 2, the federal law governing Confidentiality of Substance Use Disorder Patient Records. I understand that all user accounts will be audited on a regular basis to ensure confidential information is accessed appropriately.

I AGREE:

- To only access, use, and disclose confidential information necessary to perform my job duties.
- To safeguard and not share my user account and password or use another user's account or password.
- To safeguard confidential information and comply with applicable federal and state laws and the policies of my employer relating to the access, use, and disclosure of confidential information.
- To notify my supervisor, or applicable leadership, immediately of any known personal conflicts of interest relating to a client. A conflict of interest may exist any time the service provider or the client feel that a personal or professional relationship, either current or in the past, will have an impact on that service provider's ability to objectively engage in the delivery of that client's treatment. I agree that I will not access client data or records when a personal conflict of interest exists and acknowledge that my access to such data and records will be audited regularly to ensure my access is used appropriately.

ACKNOWLEDGMENT

By signing this agreement, I acknowledge I understand and will comply with this Agreement. I understand violation of this Agreement may result in immediate deactivation of myAvatar access and DHHS, Behavioral Health Division may refuse to allow continued services.

Contracted Employee Signature	Date
Printed Name	

I agree that if the above employee resigns or is terminated, I will notify DHHS, Behavioral Health Division Administration overseeing contract immediately upon receiving notice in order to deactivate access to myAvatar. I agree to notify DHHS, Behavioral Health Division Administration overseeing contract if conflict of interest between employee and client is identified to ensure access of client information is audited.

Contracted Employee Supervisor Signature	Date
Printed Name	