imMTrax Immunization Information System (IIS)
Provider Memorandum of Agreement

imMTrax, Montana's Immunization Information System (IIS), is a free program administered by the Montana Department of Public Health and Human Services (DPHHS) containing immunization records for participating Montanans of all ages. *imMTrax* brings together multiple immunization records from Montana healthcare providers (public and private) and parental "shot cards" to form ***one complete, electronically preserved record***. By sharing immunization records for mutual patients, *imMTrax* assists health professionals in making appropriate immunization decisions and ensuring Montanans are immunized on time, every time.

imMTrax was created with the understanding that patient confidentiality is paramount and must be protected. *imMTrax* has several built-in security features to ensure patient confidentiality. *imMTrax* uses data encryption for all data going to and from the IIS and is compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

imMTrax access is strictly controlled by use of secure, state-issued user ID numbers. *imMTrax* is only accessed by health professionals, local public health, and school personnel for authorized purposes. A variety of *imMTrax* access levels are available to ensure that authorized users only have access to the functions necessary to conduct their day-to-day immunization activities.

To apply for *imMTrax* access, a completed *Non-DPHHS Employee System/File Access Request* form and *Single User Memorandum of Agreement* is required for each individual user and must be approved by IIS staff. Additional requirements vary by access level and can be viewed on the DPHHS Immunization Program's *imMTrax* website, www.dphhs.mt.gov/publichealth/immtrax.aspx. For questions regarding appropriate access levels for individual *imMTrax* users, contact the Montana Immunization Program at (406) 444-5580.

In order to access all aspects of the *imMTrax* system, users must have access to a computer with an internet connection and a document viewer equivalent to Adobe Reader® version 6.0 or higher.

Montana has a voluntary inclusion or "opt-in" policy requiring client or guardian consent for *imMTrax* participation. Changing client consent without authorization is in violation of state confidentiality laws and may be in violation of HIPAA. When obtaining consent, the Montana Immunization Program recommends using the language in the *IIS Consent Form* available on the DPHHS Immunization Program's *imMTrax* website.

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As a requirement for *imMTrax* participation, I accept the following conditions on behalf of my facility's employees and myself:

- ☑ All facility personnel needing access to imMTrax will complete and submit separate *Non-DPHHS Employee System/File Access Requests* and *Single User Memorandum of Agreements*.
- ☑ My facility will maintain the confidentiality and security of *imMTrax* information by notifying the Montana Immunization Program whenever an authorized user discontinues employment, is terminated, or no longer need access to *imMTrax*.
- ☑ My facility will ensure that consent to participate in imMTrax is established or obtained prior to accessing a client record.
- ☑ My facility will allow clients the option to not include their information into *imMTrax* without penalty.
- ☑ My facility will not access *imMTrax* for any use outside those required to provide immunization services.
- ☑ My facility will handle information or documents obtained through imMTrax in a confidential manner and in accordance with Montana law (Uniform Health Care Information Act, MCA 50-16, Part 5) and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have read, understand and accept the terms outlined in the above *Memorandum of Agreement*. I understand that any violation of these provisions may result in termination of my facility's access privileges and/or recommendation for prosecution for non-compliance with state and federal confidentiality provisions.

_____
Provider Signature Date

_____
Provider Name, Title (Printed)

_____
Facility Name

_____
Facility Address

_____
Facility Phone Number

_____
Facility Contact Person