**ATTACHMENT A3**
**WEST VIRGINIA HEALTH INFORMATION NETWORK**
**WVDIRECT SUBSCRIPTION AGREEMENT**

## Overview

WVDirect is a service of the WV Health Information Network (WVHIN) created to promote the adoption and use of Direct Messaging for the secure and trusted transmission of patients' protected health information ("PHI"). All organizations and individuals participating in WVDirect's trusted healthcare community will be verified by a representative of the WVHIN or a Notary Public. The entity verification process allows WVDirect participants to be assured that other participants are actual members of the West Virginia healthcare community with a legitimate reason to send and receive PHI. In order to expand secure communications across WV's borders, WVDirect will establish connections with other providers of secure trusted Direct Messaging services.

In order to ensure the success and optimal utilization of WVDirect, it is important that all member entities:

- cooperate with each other,
- follow security best practices,
- provide accurate information,
- promptly update information when circumstances change,
- diligently monitor WVDirect accounts for incoming referrals, information, and requests, and
- respond to requests in a timely manner

## Terms and Conditions

By signing below, your healthcare organization, its officers, directors and employees, agree to the following terms and conditions:

1. All information provided on this form is true and accurate as of the date of execution. Business and professional licenses must be kept current in order to remain WVDirect trusted healthcare subscribers.
2. If any of the information completed on this form changes, WVHIN will be notified as soon as possible via e-mail to info@wvhin.org or phone 304-558-4503.
3. WVDirect accounts may be established for your organization as a whole and/or for individual employees. WVDirect accounts for individual employees may only be established for individual employees of your organization authorized to access, use, or transmit PHI in order to perform their job duties.
4. All organizations must identify a Designated Contact who is authorized to communicate with the WVHIN and act on behalf of the organization with respect to all aspects of WVDirect.
6. Each individual shall be responsible for all activities associated with the account assigned to him or her.
7. Your organization must notify the WVHIN within one (1) business day of an employee's last day at your organization so WVDirect access can be deleted. If an employee is terminated due to less than favorable circumstances, access to the account must be deleted immediately.

8. WVDirect accounts are to be used for the exchange of PHI between known and trusted WVDirect subscribers or with other trusted health information service providers. WVDirect subscribers may be health care providers, health plans, public health agencies, subscribers of other health information service providers, or other organizations that are involved in health care related activities and agree to comply with all the provisions of this Agreement. Use of WVDirect for unauthorized commercial purposes, e-mail spamming, or marketing are strictly prohibited.

9. Your organization will encourage best practices for patient privacy protections related to the use of each WVDirect account associated with your organization, including those accounts established for individuals. In doing so, your organization will vigorously enforce the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") Privacy and Security Rules, including, without limitation, maintaining the confidentiality and security of PHI; implement administrative, technical, and physical safeguards to prevent unauthorized access, use, and transmission of PHI; only access, use, or disclose PHI as authorized by the patient; mitigate any risks associated with an unauthorized access, use, or disclosure of PHI; require any subcontractors that receive, use, or have access to PHI to comply with the Privacy and Security Rules; and disclose only the minimum PHI necessary for the purpose for which it is disclosed.

10. In connection with HIPAA and HITECH enforcement measures, your organization will strive to minimize the risk of participation in the WVDirect trusted healthcare community for other subscribers by carefully monitoring use of your computers and the WVDirect accounts to prevent transmitting programs or data (such as malware, viruses, worms, and Trojan Horses) which may impair operability or affect patient privacy rights or breach PHI security.

11. Subscriber and WVHIN agree to be bound by the Business Associate Agreement attached to this agreement (Attachment C). This Paragraph 10 is not applicable to state or federal public health agencies.

12. In accordance with WVHIN Policies, your organization will promptly notify WVHIN if there is a breach of the security of your system that may in any way affect your WVDirect accounts.

13. Your organization will conform to Security Best Practices (Attachment D).

14. There will be no initial charge to participate in WVDirect. WVHIN reserves the right to begin charging a fee for use of the service upon 180 day written notice.

15. The WVHIN reserves the right to deny or remove access to WVDirect and the trusted healthcare community for any violation of the terms of this Agreement.

16. The WVHIN or the WVDirect Subscriber may terminate this Agreement at any time without cause upon written notice to the other.

## Member Organization Information

**Required Documentation:**

- Current copy of business license or Secretary of State verification of active business
- Current copy of professional licenses (for individual accounts)
- Current government-issued photo ID of Authorized Representative and Individuals

Organization Name (legal name) _____

Organization Mailing Address _____

City _____State _____ Zip Code _____

Organization Type _____NPI Number _____
(*Hospital, Designated Care, Specialty, FQHC, Health Department, Long Term Care, Other – please specify)*

Designated Contact Name _____Title _____

Designated Contact Email _____

Business Phone Number _____ Fax Number _____

*I hereby certify that my organization provides healthcare services to WV patients and I am authorized to act on behalf of the organization to participate in the WVDirect trusted healthcare community, to sign this Agreement, and that the information contained herein is true and accurate.*

Signature _____ Date _____
*(sign in the presence of a Notary or WVHIN authorized representative)*

**Identity of Designated Contact verified by Notary Public** *(not required if identity has been verified by a WVHIN representative)*

*I hereby certify on the date indicated below, the above-named Representative personally appeared before me, signed the document in my presence and presented a current government-issued photo ID as proof of his/her identity.*

State of _____

County of _____

Signed and attested before me on _____

Photo ID type _____

Expires/Issued Date _____

My commission expires _____

*Reserved for Notary Seal*

Notary Public Signature _____

**Identity of Designated Contact personally verified by WVHIN Representative** *(not required if identity has been verified by a Notary Public)*

Photo ID type _____ Expires/Issued Date _____

WVHIN Representative Signature _____

## Individual User Account

(Copy as needed)

Name _____ Title _____

Email _____

Phone Number _____ Fax Number _____

Signature Approval of Designated Contact _____

Signature of Individual _____ Date _____
*(sign in the presence of a Notary or WVHIN authorized representative)*

**Identity of Individual verified by Notary Public** *(not required if identity has been verified by a WVHIN representative)*

*I hereby certify on the date indicated below, the above-named Representative personally appeared before me, signed the document in my presence and presented a current government-issued photo ID as proof of his/her identity.*

State of _____

County of_____

Signed and attested before me on _____

Photo ID type _____

Expires/Issued Date _____

My commission expires _____

*Reserved for Notary Seal*

Notary Public Signature _____

**Identity of Individual personally verified by WVHIN Representative** *(not required if identity has been verified by a Notary Public)*

Photo ID type _____ Expires/Issued Date _____

WVHIN Representative Signature _____

### Return completed Subscription Agreement to:

WVHIN
100 Dee Drive OR info@wvhin.org OR Fax: 304.558.2734
Charleston, WV 25311

For questions regarding this form, please contact the WVHIN at 304.558.4503 or info@wvhin.org.