

HCFRS AUTHORIZED USER AGREEMENT
(to be completed by each HCFRS User)

Facility Name

License # (4 digits)

I, _____ (name of Authorized User), have been designated by the above named Facility to submit data and Facility Reports to, and use data and Facility Reports from, the MDPH Health Care Facility Reporting System (HCFRS) in accordance with the HCFRS Facility User Agreement and this Authorized User Agreement.

HCFRS allows Authorized Users at specified health care facilities in the Commonwealth of Massachusetts to:

- (1) Submit electronic reports of incidents, accidents, SREs, and patient abuse and neglect required to be reported by a Facility to MDPH under state law. In certain cases, a Facility also is required to immediately notify MDPH by telephone of certain serious incidents by calling: [insert name and phone number for immediate reports]; and
- (2) View and print copies of the Facility’s reports submitted to MDPH through HCFRS. Only the data entered and submitted by the Facility is accessible to the Facility.

Authorized Users access HCFRS through the Virtual Gateway (“VG”) operated by EOHHS.

I agree to use HCFRS in accordance with the terms of the HCFRS Facility User Agreement and this Authorized User Agreement as follows:

- I will not disclose my HCFRS user ID and/or password to any person or entity.
- I will access, use and/or review HCFRS data and reports only as required to perform my job duties for the above-named Facility.
- I will not share any data or reports I receive from HCFRS with others unless such sharing is necessary to perform my job duties on behalf of the above-named Facility.
- I will discuss data or reports submitted to or received from HCFRS with others only as required to perform my job duties for the above-named Facility, and I will conduct such discussions only in non-public areas to ensure that I am not overheard.
- I will not disclose any data or reports that I receive from HCFRS to third parties unless I have specific written permission from the Facility’s Access Administrator or a court order compels such disclosure.
- I will immediately report any privacy or security incidents or breaches, including unauthorized transmissions to the Facility Access Administrator and to the MDPH System Administrator.
- If I am the Facility HCFRS Access Administrator, I will immediately notify the MDPH System Administrator when an Authorized User terminates employment or is no longer authorized to access HCFRS for any reason.
- I understand that the above-named Facility or MDPH may terminate my authorization to access HCFRS at any time, for any reason.
- I understand that MDPH retains ownership of all data and reports that reside in HCFRS.
- I understand that any willful and knowing disclosure of Confidential Data to unauthorized persons is in violation of the law and may subject me to legal penalty.

I hereby acknowledge that I have received and read the HCFRS Facility Agreement and the terms and conditions of this Authorized User Agreement and agree to be bound thereby as a condition of my access to and use of HCFRS.

Signature of Authorized User: _____ Date: _____

Authorized User Complete Name: _____

Job Title and Professional Credential: _____

Work Mailing Address (include name of company and department):

Work Email Address: _____

Work Telephone: _____ Work Fax: _____

Signature of Facility Access

Administrator approving this request: _____ Date: _____

Facility Access Administrator complete name: _____

Telephone: _____

E-mail: _____

4 digit pin number _ _ _ _

(This needs to be four numbers selected by you the user.)

Month & Date of birth _ _ _ _

(For example, for September 22 enter 09 22.)