DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
IMMUNIZATION PROGRAM
(671) 735-7143

GuWebIZ User Security and Confidentiality Agreement

By signing this agreement, the Authorized Requestor and User agree to the following:

- Comply with the Department of Public Health and Social Services' (DPHSS) Guam Immunization Registry (GuWebIZ) Security and Confidentiality Policy.
- Provide immunization data to the GuWebIZ, if applicable.
- Handle identifiable patient information from GuWebIZ confidentially and will only disclose it when necessary to protect the public health, safety and welfare. We understand that we have no liability under Health Insurance Portability and Accountability Act (HIPAA) regulations for any disclosure of immunization information submitted to GuWebIZ.
- Enter administered and immunization information ideally within 24-72 hours.
- Not input false or inaccurate data, nor falsify any information or data, obtained through GuWebIZ.
- Protect and secure my credentials which provides access to GuWebIZ.
- Not allow others to use my credentials unless explicitly authorized by DPHSS Immunization Program.
- Not disclose identifiable patient information or documentation obtained from GuWebIZ to individuals for personal use or to anyone not involved in the administration, recording and reviewing of immunizations.
- Not copy the database or software used to access the GuWebIZ database without written consent and authorization from DPHSS Immunization Program.
- Immediately report any threats or violations of the GuWebIZ Security and Confidentiality Agreement and Policy to DPHSS Immunization Program.
- Allow DPHSS Immunization Program and its designated agents to review GuWebIZ transactions to ensure compliance with the GuWebIZ Security and Confidentiality Policy.
- Notify DPHSS Immunization Program when no longer employed at Clinic/School/Childcare Center/Organization or if my responsibilities changed, eliminating the need for access to GuWebIZ.
- Resubmit the GuWebIZ User Security and Confidentiality Agreement as the system automatically deactivates users after three (3) months of inactivity.

We have read, understand and agree to abide to the agreement. We understand that if there are any violations, access to GuWebIZ can be terminated and may be subject to penalties imposed by law.

Please complete the required information in the tables below:

Authorized Requestor (Manager/Supervisor) Information (PRINT):

Requestor's Name	
Title	
Email	
By signing this form, I certify that the information provided above is true, complete, and accurate to the best of my knowledge and belief. I further acknowledge and understand that any false, misleading, or omitted information may result in revocation of system access, termination of participation, or other administrative action as deemed appropriate by the Department of Public Health and Social Services (DPHSS).	
Signature:	Date:

Authorized USER Information (PRINT):

Name						
Position/Title						
Administers Vaccine?	☐ Yes ☐ No					
Business or Cell Phone						
Email Address *Required to send your GuWebIZ account access information						
Clinic/School/Childcare Center/Organization Name						
Clinic/School/Childcare Center/Organization Physical Address						
	City		State		Zip Code	
Signature:				Date:		

For DPHSS use only

Date Received: _____ Date Approved: _____

Approved by: _____ _____
Name (Print and Sign) Title

For additional information, contact:

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