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Public Health

Immunization Registry Information System (IRIS)
Authorized Site Agreement-Health Plan Enrollment Form

Name of Health Plan: _____

Physical Address: _____
City/State/Zip: _____

Mailing Address: _____
City/State/Zip: _____

Phone: _____ Fax: _____

Name of Primary Contact: _____ Title: _____

Phone: _____ Email: _____

Authorized Representative: _____ Title: _____
(e.g., Managing Physician, CEO, etc.)

Phone: _____ Email: _____

Iowa's Immunization Registry Information System (IRIS) is a statewide database of immunization histories and health screenings maintained for the purposes of reminding patients of needed immunizations, facilitating vaccine inventory management, and providing organizations with the ability to search for and update patient records and to assess the need for immunizations and health screenings.

In order to participate in IRIS, this Health Plan agrees to the following:

1. Read and abide by the IRIS Security and Confidentiality Policy, including procedures to safeguard username(s) and password(s) against unauthorized use. Access records only under this user's own username and password.
2. Use IRIS consistent with this agreement, the IRIS Security and Confidentiality Policy, and Iowa law (Iowa Code § 22.7(2) and 641 IAC Chapter 7).
3. Collaborate with IRIS staff to submit any available historical immunization data on this health plan's enrollees in IRIS.
4. Utilize IRIS data to facilitate or conduct outreach to under-immunized health plan enrollees.
5. Do not use IRIS data to market services, assist in bill collection services, or to locate or identify people for any other purpose besides the purposes found above (641 IAC 7.10(a)(4)).
6. Actively promote participation in and use of IRIS to health plan providers.

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7. For the purposes of HEDIS reports and other performance measures, the health plan will work as needed with IRIS staff to submit a file, consistent with IRIS specifications, to IRIS for its health plan enrollees.
8. Do not release data obtained from IRIS except to the person or the parent or legal guardian of the person immunized or screened, admitting officials of licensed child care centers and schools, medical or health care providers providing continuity of care, and other enrolled users of the registry (641 IAC 7.10(4)).

Failure to abide by this agreement may result in immediate suspension or termination of access to IRIS and may result in other enforcement or action. By signing below, I agree to the above conditions and will abide in accordance with Iowa law. A typed signature is acceptable.

Signature of Primary Contact: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Send completed requests to the following:
IRIS - Immunization Program Lucas State Office Bldg., 5th Floor
321 E 12th Street Des Moines, IA 50319-0075
Phone: (800) 374-3958
Fax: (800) 831-6292
Email: irisenrollment@hhs.iowa.gov

Internal Use Only
Date Received: _____ *IRIS Org #:* _____ *Username:* _____ *Initials:* _____