Department of Mental Health
Contract Provider Access Request Form
Updated: 08/27/2014

☐ New ☐ Change ☐ Revoke User ID

PART 1: User Information (please print clearly)
***Required**

*Last Name _____ *First Name _____ Initial: _____

*SSN _____ *Phone _____ User ID (Req. for Change or Revoke) _____

*Email _____

*City _____

*Provider _____

*Title _____

Division: **Behavioral Health (ADA/CPS)** ☐ **DD TCM Provider** ☐ **DD Service Provider** ☐

PART 2: Confidentiality Statement

I, the undersigned, a designated representative of the provider named above, understand that the approval and assignment of the requested ID or change enables me to access the Department of Mental Health Information Systems. I understand that Federal and State laws require confidentiality of the Department of Mental Health information and provide penalties for unauthorized access, use, or disclosure of this information. I agree to keep confidential all information made available to me through this access. I also agree not to divulge or share my password with anyone.

I agree to use the information obtained through these systems for purposes directly connected with the administration of a federal/state assisted program which provides assistance in cash or in kind, or services, directly to individuals on the basis of need. I further agree to comply with the policies and procedures established by the Department of Mental Health further governing the access and use of this information.

Violations or disclosures on my part may result in loss of access to the information systems, civil court action, or cancellation of the provider contract with the Missouri Department of Mental Health.

User Signature _____ Date _____

Supervisor Signature _____ Date _____

Local Security Coordinator _____ Date _____

DMH Central Office Use Only

Request Completed by _____ Date _____