NORTH COUNTRY COMMUNITY MENTAL HEALTH

NORTHSTAR SYSTEM USER ACCESS VERIFICATION REPORT - DUE FEB 15 2021

CONTRACTED PROVIDER	
PERSON COMPLETING FORM	
DATE SUBMITTED	

Please print legibly and complete all columns for each user. Please sign below.

USER	USER FIRST AND LAST NAME	USER PHONE NUMBER	USER EMAIL ADDRESS	USER TITLE/ROLE
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As the authorized representative for the contracted provider listed above, I verify that all of the above Users are employed by, or directly associated with, the contracted provider entity shown above. I further attest that the above listed Users are qualified, trained and have a need to access the NorthStar Electronic Health Record System operated by North Country Community Mental Health Authority, for purposes designated in the contract between the provider and North Country Community Mental Health Authority. I understand that the intent of this document is to monitor who is accessing client information which is protected under HIPAA regulation. By verifying the above Users of the Northstar System, I agree to notify North Country Community Mental Health Authority immediately upon termination of an contracted provider employee with access to NorthStar.

I further understand that any employee of the contracted provider who may currently have an authorized NorthStar user login, but whose name does not appear above, will have their NorthStar access immediate terminated upon submittal of this report.

Signature of Authorized Representative

Date

Print Name of Authorized Representative