



# Delegation Administration Form

(Please print)

Please use this form to administer a delegation agreement. For assistance or more information, please call the CDPHP IT security department at (518) 641-5588.

## Section 1: Delegate Administration

Provider Contact Person \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Company Name \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ E-Mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Indicate: Individual NPI(s) \_\_\_\_\_

- OR - Group NPI(s) \_\_\_\_\_

## Section 2: Third Party Information

Third Party Company Name \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ E-Mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

## Section 3: Confidentiality Agreement

PLEASE READ THIS AGREEMENT CAREFULLY. By signing this form I (on behalf of the provider identified above "Provider") and the third party company identified above ("Company") are requesting Company's access to the online features at the Capital District Physicians' Health Plan, Inc. ("CDPHP") Web site. We understand that in accessing these features Company may receive or have access to sensitive information including, for example, medical and financial information of CDPHP members and information about CDPHP's business or Provider's business which may constitute competitive, trade secret, or proprietary business information. Provider and Company have a duty to keep confidential any sensitive information made available or obtained through CDPHP online features and shall not use or disclose sensitive information other than for the sole purpose of implementing and administering Provider's participation agreement with CDPHP. If Company breaches this confidentiality agreement, Provider and Company agree to be jointly and severally liable for all damages and costs arising from the breach, regardless of whether a claim or legal proceeding is brought as a result. **The duty of confidentiality and liability obligations survive termination of Third Party Company's relationship with Provider and/or the termination of Provider's relationship with CDPHP for any reason.**

### Provider

User Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

### Company

User Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

**Return form to:** CDPHP, Attn: IT Security, 500 Patroon Creek Blvd., Albany, NY 12206-1057  
or fax to (518) 641-4305.

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For CDPHP Use Only: Processed By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_