



Delegation User Access Request

(Please print)

Please use this form to create, delete, or report changes in user access. For assistance or more information, please call the CDPHP IT security department at (518) 641-5588.

Section 1: Register A New User

Company Name _____ Date: ____/____/____

First Name _____ Middle Initial ____ Last Name _____

Preferred User ID (32 characters or less) _____

Telephone: () _____ - _____ Ext. _____ E-Mail: _____

Mailing Address: _____ City, State, ZIP: _____

Indicate: Individual NPI(s) _____

- OR - Group NPI(s) _____

Section 2: Delete User Access (Complete this section if deleting access)

User ID (if known) _____

Contact Name _____ Contact Telephone: () _____ - _____ Ext. _____

Section 3: Change User Information (Complete this section to change your user information)

Company Name _____

Current User ID (required) _____

Telephone: () _____ - _____ Ext. _____ E-Mail: _____

Mailing Address: _____ City, State, ZIP: _____

Indicate: Individual NPI(s) _____

- OR - Group NPI(s) _____

Section 4: Confidentiality Agreement

PLEASE READ THIS AGREEMENT CAREFULLY. By signing this form I am requesting access to the online features at the Capital District Physicians' Health Plan, Inc. ("CDPHP") Web site on behalf of the company identified above ("Company"). I understand that in accessing these features I 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 the business of CDPHP participating providers which may constitute competitive, trade secret, or proprietary business information. I have a duty to keep confidential any sensitive information made available to me or obtained by me through CDPHP online features and shall not use or disclose sensitive information other than for the sole purpose of administering Company's obligations to CDPHP and/or CDPHP participating providers. If I breach this confidentiality agreement, I 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. **My duty of confidentiality and my liability obligations survive termination of my relationship with Company and/or the termination of Company's relationship with CDPHP or CDPHP participating providers for any reason.**

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: ____/____/____