Office of Mental Health
Department of Health and Hospitals
OMHIIS Central Provider Registry System Request for Access[1]

User requesting access to OMHIIS data:

_____
Last Name First Name M.I.

Job Title: _____

OMHIIS Login ID: _____ Phone#: _____

Please list specific duties/responsibilities that justify the need for the requested roles.

Check which roles the Applicant is requesting access to: (Detailed role descriptions are listed on the OMHIIS website)

_____Provider Registry View only _____ Provider Registry View/Add/Edit data

Applicant's Signature: _____ Date: _____

Supervisor's Signature: _____ _ _____ Date: _____
(print name below)

Manager Signature (if required locally): _____ Date: _____
(print name below)

DPO's Signature: _____ Date: _____
(print name below)

Upon completion, the authorizing DPO will make the necessary changes to the applicant's access in OMHIIS. The authorizing DPO is responsible for filing the original and submitting a duplicate of this form to OMH HQ attention: Laura Austin @ fax: (225) 342-1984 or scan to email @ laustin@dhh.la.gov. If the authorizing DPO cannot make the necessary changes to the applicant's access, please contact Laura Austin for any assistance.

[1] Form ID# OMHIIS-C: Use this form when requesting access to information in the OMHIIS Central Provider Registry. This request form cannot be processed unless the applicant has completed the process for obtaining on OMHIIS account. This form will not be processed without signatures and dates by all parties. Created 8/8/2005 Updated 8/16/2006.