MSHMIS Coordinated Services Agreement
Qualified Service Organization Business Associate Agreement

The following agencies hereby enter into a "Coordinated Services Agreement"

1. _____
(name of program / agency)

2. _____
(name of program / agency)

3. _____
(name of program / agency)

4. _____
(name of program / agency)

5. _____
(name of program / agency)

6. _____
(name of program / agency)

7. _____
(name of program / agency)

8. _____
(name of program / agency)

9. _____
(name of program / agency)

10. _____
(name of program / agency)

whereby the above named agencies agree to share the following protected information:

Assessments	Assessments
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The purpose of this agreement is to coordinate services.

Furthermore, the participating agencies

1. Acknowledge that in transmitting, receiving, storing, processing or otherwise dealing with any consumer protected information, they are fully bound by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164), and cannot use or disclose the information except as permitted or required by this agreement or by law.

2. Acknowledge that they are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164), A general authorization for the release of information is **NOT** sufficient for this purpose.

3. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

4. Agree to notify each of the other participating agencies, within one business day, of any breach, use, or disclosure of the protected information not provided for by this agreement.

5. Agree to adhere to the standards outlined within the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164) which provides consumers access to their protected information, (164.524), the right to amend protected information (164.526), and receive an accounting of disclosures of protected information (164.528).

6. Agree to notify each of the other participating agencies of their intent to terminate their participation in this agreement.

7. Agree to resist, through judicial proceedings, any judicial or quasi-judicial effort to obtain access to protected information pertaining to consumers, unless expressly provided for in state and/or federal regulations.

8. Agree to complete the agency's Authorization to Release Information in addition to the MSHMIS Release, if any cell contains "restricted information" as defined in the Participation Agreement.

The Signatures Below Constitute Acceptance of the "Coordinated Services Agreement"

1. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

2. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

3. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

4. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

5. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

6. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

7. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

8. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

9. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Date

10. **Program Name:**
_____

Address:_____

Name & Title of Authorized Signature: _____

_____ _____
Signature Dat