



Prescribing Provider Authorization and Confidentiality Agreement for use of the MyOmniSource HCP Portal - Single Physician

Dear Prescribing Provider & GH Nurse:

You are invited to register with Omnitrope's on-line patient reimbursement portal, MyOmniSource.

MyOmniSource is a secure, HIPAA-compliant website where you can post and review inquiries with your dedicated Omnitrope Case Manager at your convenience. Once registered with MyOmniSource, you will have instant access to records for every patient you have enrolled in OmniSource.

MyOmniSource was created to facilitate the processing of health insurance information on behalf of patients who have consented to participate in the OmniSource Patient Support Program and have thereby agreed to have their protected health information (PHI) disclosed to coordinate the receipt, payment and administration of Omnitrope.

Use of the system will require that you first accept the Privacy Statement which you will view when you access the portal.

This form must be completed by you and faxed to 1-877-828-1052 in order for you to access the MyOmniSource Portal. Upon acceptance of your registration, you will be contacted and given user information. Access rights to the system are not guaranteed and may be terminated at any time.

Thank you,

Omnitrope Team





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I hereby request that I be provided access to the MyOmniSource Portal (“Portal”). I certify that I submit patient enrollment forms to OmniSource and/or that I am managing the patient and their respective information (which includes but is not limited to patient name, DOB, etc.) that resides within the Portal.

I understand that the information contained in the Portal constitutes PHI under the Health Insurance Portability and Accountability Act. I acknowledge and agree that I may not share my log in name and password or disclose any information I obtain from the Portal with any other individual or entity or use the PHI for any purpose other than to seek payment for the OmniSource program. I agree to report any abuse or misuse of this system to OmniSource.

The Prescriber identified in **Section 1** will be granting access to their patient’s PHI to the GH Nurse(s) identified in **Section 2** of this registration form.

Section 1 – Prescriber requesting access to the portal:

Prescriber Name: _____ DEA #: _____ Email: _____

Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____

Provider Tax ID: _____ Provider Designation: MD DO NP PA

Signed this _____ day of _____, 20__ Signed: _____ Title: _____

Section 2 – GH Nurse(s) requesting access to the portal. Also, receiving access to the patient’s PHI that belong to the Prescriber in Section 1:

Location Street Address	Location City, State & Zip	Staff Member First Name	Staff Member Last Name	Staff Member Email	Staff Member Signature

All fields are required to obtain access to the Portal.
Please fax the completed form to 1-877-828-1052