737 Bishop Street, Suite 1200 | Honolulu, HI 96813
Phone (808) 791-7557 | Toll-Free (800) 621-6998 x304 | Fax (808) 535-8314
ProviderRelations@hwmg.org

Provider Online Services Registration Form and Privacy, Confidentiality and Non-Disclosure Agreement

By signing this registration and agreement, the person/entity named below does hereby agree to the following terms and conditions for access to Online for Providers:

- To abide by the HIPAA Privacy Rules and not divulge protected health information to any unauthorized person for any reason, nor directly or indirectly use, or allow the use of, protected health information for any purpose other than that directly associated with treatment, payment, or healthcare operations related to health plan members administered by HWMG.
- Not to share the PASSWORD with any unauthorized user.
- Ensure that the password is changed whenever anyone in my office, practice or business is deleted as an authorized user.

I understand that agreeing to this statement does not preclude me from reporting instances of breach of confidentiality. I further understand that this service is only available to participating providers of HWMG and that my termination from the network will result in a termination of my Online for Providers password.

I certify that I have authority to act on behalf of the business or practice named below:

________________________________ ________________
Business or Practice Name | Tax ID # (TIN)

________________________________ ________________
Signature | Date

________________________ ________________________
Name (print) | Title

________________ ________________ ________________
Phone | Fax | Email

Please return this completed and signed form to **HWMG Provider Relations.**
Contact information is shown above.