	Shasta County Health and Human Services Agency Managed Care, Compliance & Quality Management
	Confidentiality Agreement and Acknowledgement Policy

1.0 Persons/Programs Affected *(Check all that apply)*

☒ All Staff	☐ All Managers	☐ All Supervisors	

*Each branch to have unique Persons/Programs Affected
**All employees include all employees–full-time, part-time and extra-help.*

2.0 Definitions

N/A

3.0 Policy

Shasta County employees working for the Health and Human Services Agency (HHSA) through its Mental Health Plan (MHP) or for one of its providers understand that they must keep confidential all information about a patient's identity, health, finances, lifestyle and/or demography, also known as Protected Health Information (PHI) as defined by the Health and Insurance Portability and Accountability Act of 1996 (HIPAA) and/or Personally Identifiable Information (PII) as defined in 5 U.S.C. §552a, that they may hear, see or read through their employment with Shasta County or one of its providers. HHSA employees understand they are required to keep this information in confidence forever, even after they no longer work for Shasta County or one of its providers.

4.0 Procedure

All HHSA employees shall read and sign the attached Attestation.

5.0 Attachments

N/A

6.0 Revision History

Date	No.	Action:
05/27/2014	2014-15	Revision to new format & renumbered

7.0. Other Agency Involvement

N/A

8.0 Authorization/Signatures

The above policy and procedure has been reviewed and is authorized for immediate implementation:

Donnell Ewert, MPH, Director — Date: 5/30/14

Micki Mills, Program Manager, Business & Support Services
Compliance Officer
Managed Care Compliance Program — Date: 5/29/2014

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Attestation:

I understand that legal action may be taken against me if I, at any time:

- Have, use, copy or read PHI and/or PII which is outside the scope of my assigned duties;
- Give or allow access to any PHI and/or PII which is not authorized or otherwise allowed by law;
- Do not properly safeguard PHI and PII as instructed in training and by policy;
- Release PHI and/or PII without proper authorization.

I also understand that, within the scope of my assigned duties, any login ID and password assigned to me for accessing electronic data is the equivalent of my legal signature and I will be accountable for all representations made at login and for all work done under my login ID and password. I understand that the electronic data and information stored in the county's computer systems are confidential patient, financial, organizational data or information; and I must treat them with the same care as data and information in the paper records.

I will immediately request my electronic signature be revoked if I discover or suspect that it has been or is in danger of being lost, disclosed, compromised or subjected to unauthorized use in any way.

I agree to respect and abide by all federal, state and local laws pertaining to the confidentiality of identifiable medical, personal and financial information obtained or accessed as electronic data and information. I agree to adhere to all Shasta County policies and procedures adopted to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health act (HITECH) governing the privacy, security and use of PHI and PII.

I will not access data for individuals for whom I do not have treatment, payment or business operation responsibilities. If I believe someone has compromised or broken the security of my login ID and password, I will immediately change my password and contact the HHSA Privacy Officer at (530) 225-5995 or the County IT Help Desk, if the Privacy Officer not available, at (530) 245-7575.

Confidentiality Agreement and Acknowledgement Policy

I understand that the misuse of my access to HHSA computer systems or of confidential information obtained, may subject me to disciplinary action, in accordance with Shasta County Personnel Rules and/or employee bargaining unit Memorandum of Understanding, up to and including immediate termination.

I understand that state and federal laws protect the confidentiality of this information and that I will be personally liable for any breach of these duties and may also be held criminally liable under the HIPAA privacy regulations for intentional and malicious release of identifiable health information.

I acknowledge that I have reviewed and understand the Attestation described herein. I also understand that the above required procedures will be reviewed as a Core Competency in my annual performance evaluation.

_____ _____

Employee Name/Title Date