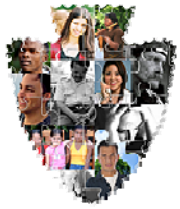
County of San Bernardino
Department of Behavioral Health
Privacy and Security Agreement
Confidentiality Statement



I, _____, acknowledge that I have read and understand the
(Please Print Legibly)

Department of Behavioral Health Standard Practice Manual, COM0943, Medi-Cal Eligibility Data System (MEDS) Policy and the associated policies listed within the policy regarding the security and privacy of Medi-Cal Personally Identifiable Information (PII).

I agree to comply with all policies and standard practices regarding confidentiality contained therein in order to obtain MEDS access. I understand that violation of these requirements may result in loss of MEDS access, disciplinary action, up to and including termination of employment, and/or civil or criminal liability.

_____ _____
Employee Signature Date

☐ The above policy and the associated policies were reviewed with the employee on _____
Date

_____ ( ) _____
Supervisor (Please Print) Supervisor Phone No.

_____ _____
Supervisor Signature Date

cc: Employee
Supervisor
Employee Personnel/201 File

PRIVACY AND SECURITY AGREEMENT REGARDING AUTHORIZED ACCESS TO THE DEPARTMENT OF HEALTH CARE SERVICES MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) FILES FOR COUNTY MENTAL HEALTH DEPARTMENT EMPLOYEES

OATH OF CONFIDENTIALITY

As a condition of obtaining access to any confidential records maintained by the California Department of Health Care Services (DHCS) in its Medi-Cal Eligibility Data System (MEDS), I _____, agree to not divulge any information acquired in the course of my assigned duties to unauthorized persons. Furthermore, I maintain that I will not publish or otherwise make public any information regarding persons who are administered Medi-Cal services such that the persons who receive or have received such services are identifiable.

Access to such data shall be *limited to County Mental Health Department (CMHD) personnel* who a) require this information in the performance of their duties; b) are in a County Mental Health Department that have entered into a Medi-Cal Privacy and Security Agreement with the California Department of Mental Health (DMH); and c) have signed an Oath of Confidentiality with the Department of Health Care Services.

By signing this oath, I agree to uphold the security and confidentiality requirements outlined by the Medi-Cal Privacy and Security Agreement signed by my CMHD and DMH, surveillance and safeguarding announcements issued by DHCS, and other applicable terms and stipulations provided by the HIPAA doctrine as well as other relevant state and federal regulations.

I hereby certify my understanding of the need to:

1. **Exercise due care to preserve data integrity and confidentiality.**
2. **Treat passwords and user accounts as confidential information.**
3. **Take reasonable precautions to ensure the protection MEDS data from unauthorized access.**
4. **Notify CMHDMEDS@dhcs.ca.gov and iso@dhcs.ca.gov of a possible security violation including unauthorized access to MEDS.**

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

Agency Name

Signature: **Date:**