

**NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
ACKNOWLEDGEMENT OF CONFIDENTIALITY
HIPAA & 42 CFR PART 2 INFORMATION**

Statement of Policy:

It is the legal and ethical responsibility of all OASAS employees to use personal and confidential patient, identifying information (referred to here collectively as "confidential information") in accordance with federal and state laws and OASAS policy, and to preserve and protect the privacy rights of the subject of the information as each employee performs their official duties.

Laws controlling the privacy of, access to and maintenance of confidential information include, but are not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA), the federal confidentiality law (42 CFR Part 2) and New York State Public Health Law. These laws apply whether the information is held in electronic or any other form, and whether the information is used or disclosed orally or in writing.

Confidential information includes information that identifies or describes an individual and the disclosure of which would constitute an unlawful disclosure of personal information. Examples of confidential information include: name, that someone has received chemical dependency treatment, fingerprints, photograph, home address and telephone number; medical record; birth date; citizenship; social security number; spouse/partner/relative's names; medical record number, health plan account number, vehicle identification number, and in some instances, race, sex and gender.

Acknowledgement of Responsibility

I have read the agreement and acknowledge that:

It is my responsibility to preserve and protect the confidentiality and security of all medical records and other confidential information relating to OASAS, its patients, activities and affiliates, in accordance with federal and state laws as well as OASAS policy.

I agree to access, use or disclose confidential information only in the performance of my official duties, where required by or permitted by law, and only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.

I agree to discuss confidential information only in my workplace and for OASAS-related purposes. I will exercise discretion when discussing any confidential information within the hearing of other persons who do not have the right to receive the information. I agree to protect the confidentiality of any medical, proprietary or other confidential information, which is incidentally disclosed to me in the course of my employment with OASAS.

(ACKNOWLEDGEMENT OF CONFIDENTIALITY HIPAA & 42 CFR PART 2 INFORMATION continued)

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I understand that psychiatric records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected by law. I understand that my access to all Agency electronic information systems is subject to audit in accordance with agency policy.

I agree not to share my Login or User ID and/or password with anyone and that any access to OASAS electronic information systems made using my Login or User ID and password is my responsibility. If I believe someone else has used my Login or User ID and/or password, I will immediately report the use to my supervisor and request a new password.

I understand that violation of any of the agency's policies and procedures related to confidential information or of any state or federal laws or regulations governing a patient's right to privacy may subject me to legal and/or disciplinary action up to and including immediate termination from my employment/professional relationship with OASAS.

I understand that I may be personally liable for harm resulting from my breach of this Agreement and that I may also be held criminally liable under the HIPAA privacy regulations for an intentional and/or malicious release of protected health information.

Signature

Date

Print Name

Bureau or Unit