COMMUNITY CARE TEAM
CONFIDENTIALITY AGREEMENT and POLICY AND PROCEDURES ACKNOWLEDGMENT

As a member of the Community Care Team I, _____(name), of _____ (member organization) have a legal and ethical responsibility to protect the privacy of individuals and families referred ("consumer") to the Community Care Team (IDN CCT) and to protect the confidentiality of their health information.

By signing this document, I understand and agree to the following:

1. "Confidential Information" means any and all non-public, medical, financial and personal information in whatever form (written, oral, visual or electronic) held or received by any member of the IDN CCT. Confidential Information shall include all information which (i) has been labeled in writing as confidential, (ii) is identified at the time of disclosure as confidential, (iii) is commonly regarded as confidential in the health care industry, or (iv) is Protected Health Information as defined by HIPAA.

2. I agree to obey all applicable laws and regulations, including HIPAA and the HITECH Act, to the extent applicable, in meeting their obligations under this Agreement.

3. I agree to only use or disclose the minimum necessary information needed for the mission of the IDN CCT (as required by the HIPAA Privacy and Security Rule 164.502, 164.514d).

4. I agree not to share or discuss any consumer health or other confidential information with others, including friends or family, who do not have a need-to-know. I understand that consumer information includes, but is not limited to, the medical records of my family, friends, co-workers, and myself.

5. I shall not disclose to unauthorized personnel, inside or outside the organization whether or not an individual is a patient.

6. I agree not to discuss any consumer health or other confidential information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeteria, on shuttle buses, on public transportation, at restaurants, or at social events. It is not acceptable to discuss clinical information in public areas, even if a consumer's name is not used.

7. I understand when utilizing or interacting with others regarding consumer health or other confidential information, this must be limited to authorized personnel.

8. I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through IDN CCT.

9. I will not disclose or in any way reveal or disseminate any information pertaining to the consumer that comes to my attention as a result of participating in the IDN CCT.

10. This Agreement may be modified or amended only with the written consent of all IDN CCT Members.

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11. No waiver of any provision of this Agreement, including this paragraph, shall be effective unless the waiver is in writing and signed by the party making the waiver.

12. I understand that should I no longer be employed with the IDN CCT member listed on this agreement all of the information to which I have been exposed remains confidential.

13. I have read and agree to comply with the IDN CCT Policy and Procedures

My signature below indicates I have read this agreement, understand its terms, and I agree to abide by this agreement.

_____

Signature of IDN CCT Member Date

_____

Name and Title of IDN CCT Member (Please print)

_____

Organization of IDN CCT Member (Please print)

Email: _____

Contact phone number(s): _____

Please add me to the: (check all that apply)

- ☐ Strafford County CCT meeting distribution list
- ☐ Portsmouth CCT meeting distribution list
- ☐ Exeter CCT meeting distribution list