

Confidential Acknowledgement Form

NHIPPS Electronic Data Management & Submission MHDS-Substance Abuse Prevention and Treatment Agency

Facility/Clinic/Program: _____

Employee Name: _____ (please print)

As a **registered** SAPTA NHIPPS user, I have read and understand the following statements regarding the management of agency and/or client-related data saved on my computer and/or the transmission of agency and/or client-related data transmitted through NHIPPS or by email:

1. I understand that I am transmitting highly sensitive client, fiscal, or employee information through the Internet and will use absolute discretion and caution when doing so.
2. I understand that client-related information accessed through NHIPPS is confidential and protected by Federal Confidentiality Regulations (42 C.F.R. Part 2) and cannot be disclosed without the client's written consent (unless otherwise provided for in the regulations) to individuals who the client has not authorized to receive such information.
3. I understand that I have been assigned user-roles that are specific to my job duties, qualifications and position and that abuse of this assignment will not be tolerated.
4. I understand that I will not disclose or share my NHIPPS password, or allow the system to save my password, or permit anyone including another employee, consultant, volunteer, intern, family or friend to access NHIPPS using my password and user-role capabilities.
5. I understand that if I have access to more than one clinic/business entity, I am the only person authorized to access and view the other clinic(s) if I am logging in from another clinic.
6. I understand that I am not authorized to access NHIPPS from another location including my home, another agency, business, library, school, relative/friend's home or laptop other than my MHDS / SAPTA approved agency unless given specific permission in advance by my direct supervisor.
7. I understand that I will not allow **unauthorized** individuals to access NHIPPS, enter information into NHIPPS, or download information from NHIPPS.
8. I understand that I may not tamper with, edit, or delete **any** information from NHIPPS unless:
 - I have the authority and clearance to do so and/or
 - I am the primary counselor and I am making changes to my own case files in accordance to NHIPPS and agency protocols
9. I understand that failure to abide by these rules will result in disciplinary action which could include termination.

Employee Signature

Date

NHIPPS Security Administrator

Date

6/16/03