Information Security Control #____________

COMMUNITY CARE

CONFIDENTIALITY AGREEMENT

Due to the confidential and /or proprietary nature of the information stored on Community Care information systems, measures must be taken to ensure that all systems in use at Community Care are secure and can only be accessed by registered users. Your account name(s) and password(s) are your unique identifiers for the system(s) that you are authorized to use.

By my signature below I certify that I understand and agree to the following:

1. My account name and password are the equivalent of my signature.
2. I am the only person authorized to use my account name and password and I will not disclose my password to anyone or allow others to use my account.
3. I will not attempt to learn another person's account name/password and I will not attempt to access information by using an account name other than my own.
4. I will change my password(s) frequently using good password creation practices to help keep my account secure.
5. I am responsible for all entries of data, information, and orders that I record into a computer system using my account name(s) / password(s).
6. If I have reason to believe that the confidentiality of my password has been compromised I will immediately call Community Care at 412-402-8770.
7. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to Community Care at 412-402-8770.
8. I will not leave a computer terminal, which I have logged into, unattended. It is my responsibility to lock my terminal or log out of the computer terminal. The only exception to this policy is responding to medical emergencies.
9. I understand that my account will be disabled on the system when I no longer have an association with Community Care.
10. I will only retrieve, attempt to retrieve or enter data that is directly related to the treatment of patients to whom I have a clinical relationship or those patients for whom I have been asked to provide a consultation. I agree to maintain the confidentiality of all such patient and/or fiscal data.
11. I understand that the law requires medical record confidentiality, and that there are statues specifically mandating the confidentiality of, among other areas, mental health, HIV, and drug and alcohol-related treatment records. Any fraudulent application or violation of confidentiality may result in the termination of access to the system.

Complete ALL of the following and return to your Provider Relations Representative. A listing of all Provider Relations Representatives may be found at www.ccbh.com/providers/networkdevelopment/providerreps/index.php

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Applicant Information: Name (Please Print)____

Applicant's Organization______________________________ Applicant's Phone Number____________________________

Office Address____

Signature____ Date____

Please select **ONE** of the three items below and provide a response for verification:

Mother's maiden name ______________________________

Pet's name ______________________________

Parent's last employer ______________________________

Supervisor's Name

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Supervisor's Phone Number

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I, as the applicant's supervisor, agree that the applicant should have access to the Community Care system. I also agree to notify Community Care when the applicant no longer needs access to the system.

Supervisor's Signature______________________________ Date ______________________________

For Community Care Only:

Network Management Review Signature ____