State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

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.

Santa Clara Valley Health & Hospital System- Mental Health Department

Agency Name

Signature: **Date:**

_____ _____