PRINT (required): ____
(Last Name, First Name, M. I.)

CONFIDENTIALITY / SECURITY AGREEMENT/ ELECTRONIC POLICIES and PROCEDURES

I understand that I will be allowed access to confidential information and /or records in order that I may perform my specific job duties. I further understand and agree that I am not to disclose confidential information and/or records without the prior consent of the appropriate authority(s) in the Cabinet for Health and Family Services.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Cabinet and its employees and agents must use and disclose an individual's health care information only for legitimate purposes as described by the federal privacy regulation, 45 CFR Parts 160 and 164. HIPAA and the privacy rule promulgated pursuant to the statute establishes in federal law the basic principle that an individual's health information and medical records belong to that individual and, with certain exceptions, cannot be used, released or disclosed without the explicit permission of that individual or their legal guardian. Even casual or informal conversation about a client's protected health information not related to legitimate legal purpose at any time, whether at work or not, may subject you to federal penalties and Cabinet sanctions.

I understand that all USERID/Passwords to access computer data are issued on an individual basis. I further understand that I am solely responsible for all information obtained, through system access, using my unique identification. At no time will I allow any other person use of my USERID/Password to logon to a network of the Cabinet, the Mainframe, or any other system. I understand my compliance is required.

I understand that accessing or releasing confidential information and/or records, or causing confidential information and/or records to be accessed or released, on myself, other individuals, clients, relatives, etc., outside the scope of my assigned job duties would constitute a violation of this agreement. I understand all data, information, documents, etc. belong to the Cabinet and I agree not to take any information in any form from the agency.

By affixing my signature to this document I acknowledge that it is my responsibility to comply with the relevant laws, regulations and policies concerning access, use, maintenance and disclosure of confidential information and/or records which shall be made available to me through the Cabinet for Health and Family Services. I further agree that it is my responsibility to assure the confidentiality of all information, which has been issued to me in confidence.

http://www.irs.ustreas.gov/pub/irs-pdf/p1075.pdf (web link for IRC 6103, 7213, 7213A, 7431) IRC 6103
- Confidentiality and Disclosure of Returns and Return Information
IRC 6103 - Safeguards
IRC 7213 - Unauthorized Disclosure Information and
IRC 7213A - Unauthorized Inspection of Returns or Return Information
IRC 7431 - Civil Damages for Unauthorized Disclosure of Returns and Returns Information
http://aspe.hhs.gov/admnsimp/pl104191.htm (Public Law 104-191- HIPAA)

______________________ ________________
Signature (required) Date Signed (required)

If a current or previous user in KYIR, please provide your username (required): ____________________

Email address (required): ____

Name of (Clinic/Facility/School) (required): ____

If VFC, Pin Number: __________ If VFC, are you a Primary or Back-up VFC Coordinator? : ☐ Yes ☐ No

Address of (Clinic/Facility/School) (required): ____

Professional Title (required): ______________________________ NPI (if applicable): __________________

If a school nurse, do you request access to enter vaccines into KYIR? ☐ Yes ☐ No
FERPA requires school nurses to procure parental consent to enter student vaccines into KYIR.

Do you give immunizations (required): ☐ Yes ☐ No

Clinic Phone Number (required): ____