****

**Casewatch Millennium® Security and Confidentiality Attestation**

**Contractor Information:**

|  |  |
| --- | --- |
| Agency/Provider Name: Click here to enter text.  |  |
| Site (if applicable): Click here to enter text. |  |
| Address: Click here to enter text. |  |
| City: Click here to enter text. Zip Code: Click here to enter text. |  |  |  |

|  |
| --- |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| First Name: |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Last Name: |

By signing this form as an authorized agency representative, I am certifying that: 1) the user identified below is an employee of the agency who understands the security and confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA), the agency, and Casewatch protocol; and, 2) their job requires the level of access to Casewatch Millennium® I have indicated below.

Agency Authorization (please **prin**t name clearly): Click here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature Date*

**User Information (Please print clearly):**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name:  | Click here to enter text. | Last Name: | Click here to enter text. |
| Email:  | Click here to enter text. | Phone:  | Click here to enter text. |
| Job Title: | Click here to enter text. |
|  |  |
| DHSP Contract # | Click here to enter text. |

By signing this form as an employee of the above Agency/Provider, I am attesting that I have been trained in the confidentiality requirements of HIPAA and that I will follow my Agency’s/Provider’s guidelines as well as Casewatch protocol pertaining to data security and confidentiality. I will not under any circumstance share my user account information or password and I will report any potential or real security or confidentiality breach to my supervisor and DHSP immediately. I understand that failure to comply with DHSP security and confidentiality protocols and HIPAA regulations may result in a 90-day suspension of my use of Casewatch and a HIPAA violation report.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employee Signature Date*

Send form to DHSP Casewatch User Support at DHSPITSupport@ph.lacounty.gov

|  |
| --- |
| **DHSP Data Management Authorization:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name Signature Date**Level of access**: **ACMS Use Only:**Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trained by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ User ID Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Activation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Activated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Level of Access**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Revocation Information:**Deactivation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deactivated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Revised: 11/28/2016*