CalREDIE Local Health Department Staff Account Authorization Form

Instructions: Local Health Department (LHD) Staff, please complete section 1 of the Account Authorization form AND the designated portion of the HIV Confidentiality Agreement. Then, send all 4 pages to your Local Health Liaison so that they may complete the forms and submit them to the CalREDIE Help Desk.

A LHD Staff member is any individual authorized by a Local Health Liaison to enter data into the CalREDIE database on behalf of a local health department required to submit reportable disease information to the State of California. A local health liaison is the only individual that can authorize LHD Staff on behalf of their health department.

Action:

☐ Add New Account ☐ Change Existing Account ☐ Delete Existing Account

1. LHD Staff Registration Information – TO BE COMPLETED BY LHD STAFF

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Direct Work Phone Number: _____ Extension: _____

Work E-Mail *(Individual account preferred)*: _____

I agree that I will protect my username and password from unauthorized use, and ensure my browser settings are up to date according to the CalREDIE browser requirements document and that I will contact the CalREDIE Help Desk, as soon as possible or within 24-hours of discovery, if I suspect that my username and password has been lost, stolen, or otherwise compromised. I certify that my username and password is for my own use, that I will keep it confidential, and that I will not delegate or share it with any other person. I agree that if I gain access to data in error that I am not responsible for or that does not belong to me, I will notify CalREDIE Help immediately so that they may assess the situation and correct the problem.

LHD Staff Signature: _____ Date: _____/ _____/ _____

***** WHERE DO I SEND THIS FORM? *****

LHD Staff, please **send pages 1 and 2 AND a signed HIV Confidentiality agreement to the Local Health Liaison** in your jurisdiction so that they may complete the forms and submit them to the CalREDIE Help Desk.

2. Local Health Liaison Approval – TO BE COMPLETED BY LOCAL HEALTH LIAISON

Level of permissions:

☐ Regional/Area/Local Enhanced Staff
- *Add/edit incidents and outbreaks, unlock closed incidents and outbreaks, delete incidents and outbreaks, merge incidents, access to reports.*

☐ Regional/Area/Local Staff
- *Add/edit incidents and outbreaks, merge incidents, access to reports, cannot unlock closed incidents and outbreaks, cannot delete incidents and outbreaks.*

☐ Read Only
- *Access to reports, cannot add/edit incidents and outbreaks, cannot unlock closed incidents and outbreaks, cannot delete incidents and outbreaks, cannot merge incidents.*

Disease Grouping:

☐ All Diseases (*No HIV/AIDS access*)
☐ All Diseases with HIV/AIDS (*Includes HIV/AIDS access*)
☐ STD Only (*No HIV/AIDS access*)
☐ STD with HIV/AIDS (*Includes HIV/AIDS access*)
☐ HIV/AIDS Only (*Includes HIV/AIDS access*)
☐ CD - All diseases except STD, TB, and HIV (*No HIV/AIDS access*)
☐ TB Only (*No HIV/AIDS access*)
☐ Other: _____

I certify that I am a liaison for my local health department. My signature on this form authorizes a Local Health Department Staff account to be created within CalREDIE for the individual listed above. A LHD Staff account will allow this individual to view, enter, edit, and delete data associated with morbidity reports for the agency. ***I will immediately notify the CalREDIE Help Desk if a user leaves or a user account needs to be modified.***

Local Health Liaison Name: _____
Local Health Department: _____
Local Health Liaison Signature: _____ Date: _____/ _____/ _____

Local Health Liaisons, send completed forms to CalREDIEHelp@cdph.ca.gov

HIV/AIDS Confidentiality Agreement

Summary of Statutes Pertaining to Confidential Public Health Records and Penalties for Disclosure

All HIV/AIDS case reports and any information collected or maintained in the course of surveillance-related activities that may directly or indirectly identify an individual are considered *confidential public health record(s)* under California Health and Safety Code (HSC) Section 121035(c) and must be handled with the utmost confidentiality. Furthermore, HSC §121025(a) prohibits the disclosure of HIV/AIDS-related public health records that contain any personally identifying information to any third party, unless authorized by law for public health purposes, or by the written consent of the individual identified in the record or his/her guardian/conservator. Except as permitted by law, any person who negligently discloses information contained in a confidential public health record to a third party is subject to a civil penalty of up to $2,500 plus court costs, as provided in HSC §121025(e)(1). Any person who willfully or maliciously discloses the content of a public health record, except as authorized by law, is subject to a civil penalty of $5,000-$10,000 plus court costs as provided by HSC §121025(e)(2). Any willful, malicious, or negligent disclosure of information contained in a public health record in violation of state law that results in economic, bodily, or psychological harm to the person named in the record is a misdemeanor, punishable by imprisonment for a period of up to one year and/or a fine of up to $25,000 plus court costs (HSC §121025(e)(3)). Any person who is guilty of a confidentiality infringement of the foregoing type may be sued by the injured party and shall be personally liable for all actual damages incurred for economic, bodily, or psychological harm as a result of the breach (HSC §121025(e)(4)). Each disclosure in violation of California law is a separate, actionable offense (HSC §121025(e)(5)).

Because an assurance of case confidentiality is the foremost concern of the California Department of Public Health, Office of AIDS (OA), any actual or potential breach of confidentiality shall be immediately reported. In the event of any suspected breach, staff shall immediately notify the director or supervisor of the local health department's HIV/AIDS surveillance unit who in turn shall notify the Chief of the HIV/AIDS Case Registry Section or designee. OA, in conjunction with the local health department and the local health officer shall promptly investigate the suspected breach. Any evidence of an actual breach shall be reported to the law enforcement agency that has jurisdiction.

Employee Confidentiality Pledge

I recognize that in carrying out my assigned duties, I may obtain access to private information about persons diagnosed with HIV or AIDS that was provided under an assurance of confidentiality. I understand that I am prohibited from disclosing or otherwise releasing any personally identifying information, either directly or indirectly, about any individual named in any HIV/AIDS confidential public health record. Should I be responsible for any breach of confidentiality, I understand that civil and/or criminal penalties may be brought against me. I acknowledge that my responsibility to ensure the privacy of protected health information contained in any electronic records, paper

documents, or verbal communications to which I may gain access shall not expire, even after my employment or affiliation with the Department has terminated.

By my signature, I acknowledge that I have read, understand, and agree to comply with the terms and conditions of this Confidentiality Agreement.

_____
Employee name (printed)

_____
Employee signature

_____
Date

_____
Supervisor name (printed)

_____
Supervisor signature

_____
Date

_____
Chief name (printed)
HIV/AIDS Case Registry Section
Office of AIDS
California Department of Public Health

_____
Chief signature

_____
Date

THIS AGREEMENT IS NOT VALID UNTIL SIGNED BY THE CHIEF OF THE HIV/AIDS CASE REGISTRY. PLEASE RETAIN A COPY OF YOUR RECORDS