

To be given access to the Screening Information System (SIS), you must read the Oath of Confidentiality below, print it, and sign and date it. Then FAX the Oath of Confidentiality to either Sara Goldman or Jamie Matteson at (510) 412-1551.

NT Practitioner / NT Data Entry Staff - SIS Oath of Confidentiality

I have been informed and understand that I will be handling documents and data provided by the Department of Public Health under assurance of confidentiality to the clients to whom the documents and data pertain, and to their health care providers as expressed in the privacy policies published by the Genetic Disease Screening Program.

I agree that I shall not discuss, share or otherwise communicate to any unauthorized person any confidential information, including the individual case records or reports, without the prior specific written permission of the Chief of the Genetic Disease Screening Program and shall be bound by the privacy policies of the Genetic Disease Screening Program, and applicable state and federal law.

I will keep all confidential material in my possession in a secure manner. I will not discard any confidential material, but will dispose of it by shredding. I understand that If NT data is entered directly into SIS and the chromosome risk assessment is Screen Positive, the NT Practitioner or a licensed medical professional is required to disclose the results to the patient and offer her the follow-up options as provided by the California Prenatal Screening Program. I understand that a medical assistant may not discuss any case interpretations or follow-up options with the patient.

Access to copies of the following privacy policies are available at: <http://sis.dhs.ca.gov/>.

California Government Code Section 6250, et. Seq.
(California Public Records Act)

California Civil Code, Division 3, Part 4, Title 1.8, Sections 1798-1798.65
(Information Practices Act of 1977)

California Health and Safety Code Division 104, Part 5, Chapter 1
(Hereditary Disorder Act)

Genetic Disease Screening Program's Privacy Policy

User (*Print*) _____ Signed _____

Credential / License / Certification # _____ Date _____

NT Practitioner | Genetic Counselor | Licensed Medical Professional | Medical Assistant
(*Circle One*)

Witness (*Print*) _____ Signed _____

Date _____

Office Address and Phone Number: _____

E-mail Address: _____