VERMONT
DEPARTMENT OF HEALTH

VERMONT DEPARTMENT OF HEALTH (VDH)
Integrated Child Health Database

ACCESS AND CONFIDENTIALITY/ PRIVILEGE AGREEMENT

STATEMENT TO HEALTH CARE PROVIDER:
18 VSA § 5087 establishes a statewide birth information network designed to identify newborns who have specified conditions which may respond to early intervention and treatment. The network is designed to help coordinate care for infants and children with special health needs. The law directs the commissioner of health to take measures to protect the confidentiality of the information and to comply with the Health Insurance Portability and Accountability Act (HIPAA).

HEALTH CARE PROVIDER'S AGREEMENT

As a health care provider with access to information within the Childhood Health Profile on the VDH integrated child health database regarding children to whom I provide services, I hereby agree to the following:

I will access confidential and privileged information for which I have a need to know only in order to provide health care services for my patients.

I will not in any way: divulge a copy; release; sell; loan; review; alter; or destroy any confidential and privileged information except as properly authorized within the scope of my professional activities as a health care provider.

I will not misuse confidential and privileged information or treat such information carelessly.

I will safeguard and not disclose my access code or any other authorization I have that allows me to access confidential and privileged information. I accept responsibility for all activities undertaken using my access code and other authorization.

I will report to the Vermont Department of Health activities by any individual or entity that I suspect may compromise the protection and privacy of confidential and privileged information. Reports made in good faith about suspect activities will be held in confidence by the Vermont Department of Health to the full extent permitted by law, including the name of the individual reporting the activities.

I understand that I have no right or ownership interest in any confidential and privileged information to which I have access.

I understand that failure to comply with this Agreement may result in loss of privileges to access confidential and privileged information. The Vermont Department of Health may, at any time, revoke my authorization or access to confidential and privileged information.

I understand that, under 18 VSA 18 § 1001(d), a confidential public health record shall not be:

a. Disclosed or discoverable in any civil, criminal, administrative or other proceeding.
b. Used to determine issues relating to employment or insurance for any individual.

I understand that confidential information may not be used for research purposes.

I understand that my obligation under this Agreement will continue after termination of my privileges and access, which are subject to periodic review, revision, and, if appropriate, renewal.

I understand that any person who willfully or maliciously discloses the content of any confidential public health record with written authorization or as authorized by law shall be subject to a civil penalty of not less than $10,000.00 and not more than $25,000.00 and costs and attorneys' fees as determined by the Court.

HEALTH CARE PROVIDER:

DATE: _____ _____

(Health Care Provider Signature) (Credential/Role)

_____

(Provider Name Printed - First Name, Middle Initial, Last Name)

_____

(Practice Name)

_____

(Practice Mailing Address-Street, Town, Zip Code)

_____

(Practice Phone Number)

_____

(Health Care Provider Email Address)

View Access Request (check all that apply):

☐ Hearing

☐ Dried Blood Spot NBS

☐ Blood Lead

☐ Developmental Screening