COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Confidentiality Acknowledgment

As a Department of Mental Health (DMH) Workforce Member, I may have access to Protected Health Information (PHI). PHI means any individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, or the past, present or future payment for health care provided to an individual.

By signing below, I acknowledge the following:

I have completed the DMH Privacy Training on the DMH Privacy Handbook

DMH policies and procedures, Massachusetts law, and federal law prohibit the unauthorized use or disclosure of PHI.

I will not share PHI with other DMH Workforce Members or individuals outside of DMH unless doing so is necessary to do my job and DMH policies or procedures permit the use or disclosure.

I will not attempt to access or look at PHI other than what is required to perform my job.

I will not remove PHI from DMH premises unless doing so is necessary to perform my job.

I will abide by all DMH policies and procedures relating to PHI.

After I leave the DMH Workforce, I will continue to observe DMH policies and procedures with regard to PHI that I had access to while a DMH Workforce Member.

I understand that if I violate DMH polices or procedures relating to PHI, I may be subject to employment or contractual sanctions, up to and including the termination of my employment, or contract, and also may be subject to civil liability or criminal prosecution.

_____ _____
Signature Date

_____
Printed Name

_____
Title

Submit this form to your DMH Human Resource Office