VERMONT
DEPARTMENT OF HEALTH

VERMONT DEPARTMENT OF HEALTH (VDH)
Integrated Child Health Database

ACCESS AND CONFIDENTIALITY/PRIVILEGE AGREEMENT

STATEMENT TO EARLY EDUCATOR OR COMMUNITY 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).

EARLY EDUCATION AND/OR COMMUNITY PROVIDER AGREEMENT
As an early education or community 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 (or education services) for my patients (or children enrolled in the early care and/or education program I am affiliated with or operate).

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 or education 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 negligently discloses the content of any confidential public health record without written authorization or as authorized by law shall be subject to a civil penalty not to exceed $2500.00, and that anyone who willfully or maliciously discloses a public health record shall be subject to a civil penalty of not less than $10,000.00 and not more than $25,000.00 and other costs and attorneys' fees as determined by the Court.

EARLY EDUCATION AND/OR COMMUNITY PROVIDER:
By signing this agreement **I attest that I have obtained a valid HIPAA authorization signed by the parent or legal guardian of the child for whom I currently provide services; I attest that I can provide a copy of this release if requested by the Vermont Department of Health;** and I agree to adhere to the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws pertaining to confidentiality.

EARLY EDUCATION AND/OR COMMUNITY PROVIDER:

DATE: _____

_____
(Provider Signature) **(Credential/Role)**

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

_____
(Business, School, or Organization Name)

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

_____
(Phone Number)

_____
(Provider Email Address)

Identify Your Organization Type:
- ☐ Early Care and Education
- ☐ Children's Integrated Services
- ☐ Head Start/Early Head Start
- ☐ Home Health Nursing Services
- ☐ Early Childhood Special Education/School District

View Access Request
(check all that apply):
- ☐ Hearing
- ☐ Developmental Screening
- ☐ Blood Lead