NEW YORK STATE DEPARTMENT OF HEALTH
HIV SURVEILLANCE AND PARTNER SERVICES
ATTESTATION OF CONFIDENTIALITY
FOR STAFF WHO WORK WITH HIGHLY CONFIDENTIAL DATA

As an employee of New York State, Health Research Inc., a local health department or as a visiting professional, student or subcontracted employee, I understand that I may have access to highly confidential and/or identifying information on persons reported as part of routine or supplemental surveillance projects and/or HIV partner services to the New York State Department of Health (NYSDOH) as a consequence of my work.

Highly confidential or identifying information includes, but is not limited to, names, initials, date of birth, date of death, social security number, medical record or insurance number, NYS Department of Corrections and Community Supervision identifier (NYSID/DIN), address, telephone number, medical conditions, identifying tattoos/scars in combination or alone. As a consequence of my work, I may have access to protected and identifying information from electronic data, paper records, or information obtained during an interview. Information may originate from records of hospitals, laboratories, health care providers, medical/health clinics, drug treatment centers, and/or jails and correctional facilities.

I hereby acknowledge that I have received training regarding the "New York State Department of Health's Confidentiality Policies and Procedures for Staff Conducting HIV/AIDS Surveillance and HIV Partner Notification Activities" and will abide by all appropriate laws, regulations and protocols regarding the confidentiality of protected information. Illegal procurement or disclosure of HIV information is punishable by a fine of up to $5,000 per occurrence. Willful violations are punishable by imprisonment of up to one year. If I am a New York State or Health Research, Inc. employee, I understand that any violation of these rules will be documented and that I may be subject to disciplinary action, including discharge from my position. If I am a consultant/contractor/student/intern or have access to these data in another capacity, I understand that violations will be pursued as allowed by the laws of New York State.

PLEASE CHECK YES OR NO FOR THE FOLLOWING STATEMENTS

☐ **Yes** ☐ **No** I am a NYEHMS user.

☐ **Yes** ☐ **No** I have VPN/remote desktop access.

☐ **Yes** ☐ **No** I have access to HIV Surveillance Data via VPN/remote desktop.

INITIAL EACH ITEM BELOW:

By initialing the following statements and signing this attestation, I agree that:

_____ I will never discuss, release or divulge any information that could identify persons reported except to authorized persons and in the performance of my job-related duties.

_____ I will conduct telephone calls that require the discussion of identifying information as discreetly as possible, only within a protected and private area and out of hearing range of unauthorized persons to protect against disclosure of confidential information.

_____ I will not use cell, mobile or cordless telephones to discuss identifying information. Persons authorized to use cellphones for the conduct of their work should abide by program specific operational procedures to protect against disclosure of confidential information.

_____ I will not use cameras or other video/audio/text-capable recording devices/tools, including cellphone cameras and artificial intelligence, to record meetings or other interactions within secure, restricted access areas without written supervisory approval.

_____ I will not seek access to health information for which I have not been granted explicit access as a function of my job.

_____ I will not remotely access highly confidential HIV Surveillance or Partner Services data (e.g., using VPN/remote desktop), without expressed permission and approval from the Division of HIV/STI Epidemiology, Evaluation and Partner Services.

_____ I will handle highly confidential data as discreetly as possible, and I will keep confidential data with which I am working out of the view of unauthorized persons.

_____ I will not receive unauthorized visitors in the restricted access area in which I work, unless they are announced, and all identifying and confidential materials are properly secured.

_____ All highly confidential data and hard copy files will be kept in a double-locked file cabinet except when in use.

_____ To prevent unauthorized access, I will "lock" my computer when I temporarily leave my workstation and will log off my computer at the end of each day.

_____ I will encrypt, and password protect electronic files containing personally identifying information and will store these files in the appropriately secure location on the LAN. When no longer needed, electronic documents will be permanently deleted per the NYSDOH required procedures.

_____ I am responsible for preventing unauthorized access to or use of my security badge, keys, passwords, authentication tokens and alarm or access codes.

_____ I will not share my security badge, authentication tokens, passwords or alarm codes with anyone.

_____ I will not allow software to retain my password (auto connect/auto save).

_____ I will not copy, write, download, or store any highly confidential data to a local hard drive or portable media (including but not limited to floppy disk, CD, zip or flash drive).

_____ I will not fax any highly confidential HIV Surveillance or HIV Partner Services information.

_____ I will not e-mail any highly confidential or identifying data.

_____ Any transfer of protected and identifying data will be done via the secure file transfer utility (FTU) on the NYSDOH Health Commerce system (HCS) or the Center for Disease Control and Prevention (CDC) Secure Data Network (SDN) using the appropriate encryption and only to authorized persons.

_____ When transporting information that is highly confidential, I will employ appropriate security measures to ensure that the material remains protected, including delinking personally identifying information from disease information.

_____ When disposing of hard copy documents that contain personal identifying or highly confidential information, I will shred materials using a crosscut shredder located within the restricted area.

_____ Reports, records or information are to be released only in accordance with established policies.

_____ I will notify my supervisor immediately of all suspected and actual breaks in protocol and breaches of confidentiality.

_____ Any exception to these policies must have written pre-approval of the AIDS Institute Director or his/her designee.

_____ I understand that I am bound by these policies, even upon resignation, termination or completion of my activities.

Employee Name (Please Print)	Employee Signature
Email Address	Date of Training
Bureau/Division/Regional Office/County	Building and Room No./ City

Please check the box that applies to your status:

- ☐ State/HRI
- ☐ County
- ☐ Partner Services
- ☐ Other (please specify)

I hereby certify that I have provided training for this employee on confidentiality and have provided a copy of pertinent New York State laws, regulations and policies regarding confidentiality.

Trainer's Signature	Date