Massachusetts Access to Recovery ("ATR") Participating Provider

Confidentiality Pledge

ATR PROVIDER staff that will have access to confidential information about ATR participants must attend mandatory Confidentiality Training and sign this Confidentiality Pledge. ATR PROVIDER is required to send a copy of signed Confidentiality Pledge(s) to the Massachusetts Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) and to maintain the original signed Pledge(s) for a minimum of seven (7) years beginning on the first day after the final payment as specified in the Provider Agreement and shall make all pledges available to DPH/BSAS and/or Advocates for Human Potential (AHP) for inspection immediately upon request.

I, _____, understand that in the course of my work for _____ (an ATR Provider) I may have access to information about participants in the Massachusetts Access to Recovery program (ATR), and other information related to the ATR program including information related to use and access to WITS VMS (Web Infrastructure for Treatment Services Voucher Management System). I acknowledge that this information is confidential. This confidential information may be contained in paper forms, computerized data bases including but not limited to WITS VMS, or other media.

I understand that access to confidential information is provided only for the purpose of completing my work responsibilities. I understand that Massachusetts and federal law protect this confidential information from unauthorized use and disclosure.

I understand that the unauthorized use or disclosure of any confidential information may cause serious harm to individuals participating in ATR and damage to the ATR program, and may be a violation of state and/or federal law. DPH/BSAS may terminate a ATR Provider Agreement, bar future participation in DPH/BSAS contracts and/or take other legal action.

In order to preserve the confidentiality of ATR and other DPH/BSAS confidential information and the integrity of the data systems to which I have access, I acknowledge and agree that:

DATA USER INITIALS BELOW:

1. _____ Regardless of how it was obtained, I will respect the confidentiality of all ATR confidential information to which I have access. I will not disclose any confidential information unless authorized by my employer in accordance with ATR Program Requirements. I will not attempt to access confidential information to which I am not entitled.
2. _____ I will not discuss any confidential information related to an ATR participant or other DPH/BSAS confidential information except in the performance of ATR-related duties and only if authorized.
3. _____ I will conduct any related activities, including but not limited to discussion with others authorized to access this confidential information in accordance with all applicable ATR Program Requirements.
4. _____ I will ensure the physical security of all ATR confidential information when I leave my work area unattended through the use of locked files, locked workstations, locked offices, and similar methods.

5. _____ Any passwords and/or identification codes assigned to me for access to computers containing ATR confidential information are intended for my professional use only as related to my duties for a ATR Provider. I understand that I will be accountable for all data, reports, and other activities performed under my assigned passwords and identification codes.
6. _____ I will not disclose or share my passwords/ID codes and I will be responsible for ensuring that any employees that I supervise are assigned their own passwords/codes.
7. _____ I will immediately report to my supervisor or the ATR program contact at AHP any misuse of computing resources or ATR or DPH/BSAS confidential information, or anything which leads me to suspect that the security of my own passwords has been compromised.
8. _____ I will report to my supervisor, or if I am the supervisor, to the ATR program director at AHP, any inappropriate disclosure of confidential information related to a ATR participant or other DPH/BSAS confidential information.
9. _____ I will not remove any ATR or other DPH/BSAS confidential information from the work place unless explicitly authorized by DPH/BSAS and my supervisor.
10. _____ I will not utilize email as a means of communicating participant identifying information. This includes forms and documents such as the participant Referral Form.
11. _____ I will not place confidential information on a laptop or transmit the information electronically unless explicitly authorized by the ATR program and my supervisor. If I am authorized, I will be responsible for following all relevant standards for use and transmission of the information.
12. _____ I understand that violation of these rules could result in the denial of access to ATR or other DPH/BSAS confidential information.
13. _____ I understand that ATR participant data may not be published or publicly released without prior written approval by DPH/BSAS.

I sign this agreement with the understanding that I am required to complete the ATR Confidentiality Provider Training and agree to complete any future training as may be required by the ATR program or by my Supervisor.

_____ _____

Confidential Information User's Signature Date

_____

Confidential Information User's name (printed or typed)

_____

ATR Provider

AHP Contact:
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