Citywide Immunization Registry
We help you call the shots!
www.nyc.gov/health/cir

CIR Facility Code (if available): _____
Facility Name: _____
EHR Vendor: _____

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Mary T. Bassett, M.D., M.P.H.,
Commissioner
Phone: (347) 396-2400
Fax: (347) 396-2559

Health Care Provider Confidentiality Statement

Please read this statement carefully. Be sure to ask DOHMH personnel for clarification about anything you don't understand, before signing this Agreement. Refusal to sign this Agreement will result in immediate denial of access to Department of Health and Mental Hygiene records and could result in the termination of a contract.

Everyone who has access to Department medical and personal records is required by law to safeguard the confidentiality of personal health and other information contained in these records (the "Confidential Information"). Unauthorized disclosure of Confidential Information is a violation of New York City Health Code Section 11.11 (d) and state law, subject to civil and/or criminal prosecution, penalties, forfeitures and legal action. See Section 558(e) of the City Charter and Section 3.11 of the New York City Health Code. Former employees of the Health Care Provider, too, must continue to comply with confidentiality requirements after leaving employment with the Health Care Provider.

The Citywide Immunization Registry (CIR) will provide Health Care Providers with data from CIR and\or Master Child Index (MCI), in any fields, format or media as may be pertinent to the work required in accordance with the following terms and conditions:

1. Health Care Providers acknowledge that they and their employees and agents have been provided with access to Department of Health and Mental Hygiene information that must be held in the strictest confidence, and agree that they shall continue to hold these data in the strictest confidence, except as provided herein.

2. Health Care Providers shall request data and fields as needed for patient care or public health purposes.

3. Each Health Care Provider agrees that no agent, employee, or other individual to whom she or he provides information obtained from the Department shall attempt to contact any person who is the subject of any DOHMH report or record except for patient care or public health purposes

4. Each Health Care Provider agrees that none of his or her agents, employees or any other individuals to whom information obtained from Department records is provided shall at any time disclose the contents of ANY record, report or other data provided by DOHMH, including, but not limited to, personal identifying information of any individual in the CIR database, except for patient care or public health purposes

5. Each Health Care Provider acknowledges that all data given by DOHMH shall remain the property of DOHMH.

6. Neither the Health Care Providers nor any of their agents or employees shall compile any aggregate data or statistics from the CIR and\or MCI databases, nor publish any reports, based upon, or which are the results or analyses of, DOHMH data or records, in any medium of communication, or repackage any identifiable DOHMH data for offer or sale to or use by any other prospective purchaser, except as expressly authorized in writing by DOHMH.

7. In the event that any Health Care Provider is authorized to use DOHMH data for any publication, the Health Care Provider agrees that such data shall only be published in the aggregate and not include any identifying information about any person, or any information which it is possible to render identifiable in combination with any other data sets or data bases.

8. The terms of this or any other agreement between the Health Care Provider and any entity requiring the Providers to maintain the confidentiality of DOHMH data shall survive the expiration of the procurement and the completion of the project.

9. The Health Care Providers shall provide each of their agents, employees, or vendors having access to DOHMH data with a copy of this agreement and require that each such person or entity understand and individually agree to comply with all applicable terms and conditions.

10. Should the person signing this agreement leave their position the entity agrees to notify DOHMH as to who the replacement will be and a new agreement will be signed by the person taking over the duties.

AGREEMENT

_____ has read and understand the above statement. _____ agrees to keep strictly confidential all confidential information received from the records of the Department of Health and Mental Hygiene. _____ understands fully the consequences if confidential information is disclosed without proper authorization. _____ discussed, and will continue to discuss, with DOHMH personnel any questions about what is confidential or to whom confidential information may be revealed.

DATED: _____ SIGNATURE: _____ PRINT NAME: _____

ADDRESS: _____ JOB TITLE: _____

E-MAIL: _____ PHONE: _____ FAX: _____ ***FAX completed form to*: (347) 396-2559**