

**State of Nebraska, Department of Health and Human Services (DHHS)
External Access Confidentiality Statement**

I agree that any and all DHHS information gathered in the performance of my duties, either independently or through access to any DHHS system, shall be held in the strictest confidence.

I understand that DHHS, as a covered entity under HIPAA, must make reasonable efforts to limit my access to protected health information to the minimum necessary to accomplish the intended purpose¹. I agree that information I use, disclose, or request will also be limited to the minimum necessary for the purpose of treatment, payment, or operation.

I agree that any and all information shall be released to no one other than DHHS or authorized individuals in strict compliance with any business agreements or contracts in force.

I agree to meet all applicable state and federal laws and regulations and to comply with all DHHS Security and Privacy Policies, Procedures and Standards.

I acknowledge that the Policies on Information Technology Security are available to me for review and that I have been informed and understand that it is my responsibility to become familiar with and abide by these policies.

I understand that if I wrongfully disclose the information described above, I may be subject to disciplinary action by my employer, and civil and criminal penalties.

I understand that due to security restrictions, N-FOCUS information may only be accessed over a secure wired connection. I agree not to access any N-FOCUS information over any wireless access device or service.

Employee Information

(Please clearly print all information except for signatures.)

Employee Name: _____

Employee Title/Position _____

Employee Signature _____ **Date** _____

Work Phone _____ **Work E-mail** _____

Employer/Agency Name _____

Address _____ **City** _____ **Zip Code** _____

Employee Work Site (if different than above address) _____

Immediate Supervisor Information

Printed name: _____

Position Title: _____

Work Phone _____ **Work E-mail** _____

Signature: _____

¹ Pursuant to HIPAA 45 CFR 160-164
EACS v.1 approved 10-23-2003 (Revised 04/17/2008)
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Immediate Supervisor Information continued

Does this supervisor have access to a DHHS Application? _____ Lotus Notes? _____
Yes or No Yes or No

If not, who should be listed as supervisor on the requested Application? Give Name and Position

Contact Person if different from immediate supervisor _____

Phone _____ E-mail _____

Other Information

Does your access request relate to: Medicaid Claim Status and/or Client Eligibility,
 N-FOCUS CHARTS

Other (Specify) _____

Have you had access to any DHHS applications such as N-FOCUS or CHARTS at another work place? _____
Yes or No

If Yes, What application and Where? _____

Are you replacing existing staff? _____ If Yes, Name _____
Yes or No

Date employee left _____ (OR)

Employee has new position in the same company and still needs existing access _____ Yes _____ No

Position and Location _____

Original signed copy to be sent to DHHS

***** For DHHS Use Only *****

Employee Name _____

Information received _____ Sent to Help Desk _____
Date Date

Comments:

NFOCUS Position # _____