

**COMMUNITY CARE TEAM
CONFIDENTIALITY AGREEMENT and RESPONSIBILITIES AND EXPECTATIONS
ACKNOWLEDGMENT**

As a member of the Community Care Team I, _____ (name),
of _____ (member organization) have a legal and ethical
responsibility to protect the privacy of individuals and families referred (“consumer”) to the Community Care
Team (CCT) being operated by Strafford County and Seacoast Public Health Networks and to protect the
confidentiality of their health information.

By signing this document, I understand and agree to the following:

1. “Confidential Information” means any and all non-public, medical, financial, and personal information in whatever form (written, oral, visual or electronic) held or received by any member of the CCT. Confidential Information shall include all information which (i) has been labeled in writing as confidential, (ii) is identified at the time of disclosure as confidential, (iii) is commonly regarded as confidential in the health care industry, or (iv) is Protected Health Information as defined by HIPAA.
2. I agree to obey all applicable laws and regulations, including HIPAA and the HITECH Act, to the extent applicable, in meeting their obligations under this Agreement.
3. I agree to only use or disclose the minimum necessary information needed for the mission of the CCT (as required by the HIPAA Privacy and Security Rule 164.502, 164.514d).
4. I agree not to share or discuss any consumer health or other confidential information with others, including friends or family, who do not have a need-to-know. I understand that consumer information includes, but is not limited to, the medical records of my family, friends, co-workers, and myself.
5. I shall not disclose to unauthorized personnel, inside or outside the organization whether or not an individual is a patient.
6. I agree not to discuss any consumer health or other confidential information where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeteria, on shuttle buses, on public transportation, at restaurants, or at social events. It is not acceptable to discuss clinical information in public areas, even if a consumer’s name is not used.
7. I understand when utilizing or interacting with others regarding consumer health or other confidential information, this must be limited to authorized personnel.
8. I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through CCT.
9. I will not disclose or in any way reveal or disseminate any information pertaining to the consumer that comes to my attention as a result of participating in the CCT.

CONFIDENTIALITY AGREEMENT and POLICY AND PROCEDURES ACKNOWLEDGMENT

10. No waiver of any provision of this Agreement, including this paragraph, shall be effective unless the waiver is in writing and signed by the party making the waiver.
11. I understand that should I no longer be employed with the CCT member agency listed on this agreement, all of the information to which I have been exposed remains confidential.
12. I have read and agree to comply with the CCT Policy and Procedures.

My signature below indicates I have read this agreement, understand its terms, and I agree to abide by this agreement.

Signature of CCT Member

Date

Name and Title of CCT Member (Please print)

Organization of CCT Member (Please print)

Email: _____

Contact phone number(s): _____

Please add me to the following distribution list(s): (check all that apply)

- Strafford County CCT meeting distribution list
- Portsmouth CCT meeting distribution list
- Exeter CCT meeting distribution list

Please upload this document to [Drop Box](#) or visit [SCPHN.org](#) or [SeacoastPHN.org](#) to find the link