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| **DEPARTMENT OF HEALTH SERVICES**  F-00044 (01/2017) | **STATE OF WISCONSIN** |

**USER AGREEMENT FOR SYSTEM ACCESS**

Completion of this form is voluntary, but it is required to gain access to the Click here to enter System (Application) Name.

I understand that the information in the Click here to Enter Application Name is protected by federal and state laws. I agree to be legally and ethically responsible for protecting the confidentiality, integrity, and security of all protected data and information to which I have access in the Click here to Enter Application Name, including, but not limited to, financial information, client/patient identifiable information, or protected health information. Protected health information is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual.

I will only access and use the Click here to Enter Application Name in strict conformance to all applicable laws and policies governing confidential information. This means, among other things, I agree to the following:

* I will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly and clearly authorized within the scope of my job duties and all applicable policies and laws. I will access only the minimum necessary information that is needed to complete my authorized tasks. Unauthorized disclosure or use of this information or the falsification of such records is strictly prohibited. I will not re-disclose any information I have accessed unless needed to complete my authorized tasks and as allowed by law.
* I will safeguard and not disclose my user ID and password or other authentication/authorization information to anyone. I will not leave unattended a computer to which I have logged on without first either locking it or logging off. If I believe that the confidentiality of my user ID, password, or other authentication/authorization information has been compromised, I will immediately inform my agency’s Security Officer.
* I will report to my Security Officer, contract administrator, or department management any conditions or activities that I reasonably believe may potentially compromise confidential information.
* If I am aware that I am ending my employment, I must promptly provide my agency’s Security Officer and management with the end date of my employment so that my access to the Click here to Enter Application Name will be revoked effective that date. This notice must occur before the last day of my employment. When my association ends with any program(s), I will not take any confidential information associated in any way with the program(s) with me. I will return all such information to my direct supervisor or other authorized staff or destroy it in a manner that renders it unreadable and unusable by anyone.

I understand that my actions in the Click here to Enter Application Name may be intercepted, monitored, recorded, copied, audited, inspected, or disclosed to authorized personnel. Improper use or unauthorized access of this system may result in administrative disciplinary action and civil and criminal penalties.

This Agreement sets forth the terms and conditions governing my use of the Click here to Enter Application Name. **BY SIGNING THIS FORM, I ACCEPT, WITHOUT LIMITATION OR QUALIFICATION, ALL OF THE TERMS AND CONDITIONS IN THIS AGREEMENT.**

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| Print – Name of User and Professional Title | Local Educational Agency/County/ADRC Name |
| Click and type | Click and type |
| **SIGNATURE** – User | Date |

Choose one and type or right click and remove content control