DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00639 (02/2020)

STATE OF WISCONSIN
Wis. Stat. § 15.04(1)(m), Privacy Law

AGENCY DATA SECURITY STAFF USER AGREEMENT

Personal information you provide may be used for secondary purposes.
INSTRUCTIONS: After completing the signatures, email this form to dhscaresaims@dhs.wisconsin.gov.

Name – Agency

Name – Security Officer (Last, First MI)		Title
Employing Agency		Work Address
Phone Number	Fax	Email Address
Name – Backup Security Officer (Last, First MI)		Title
Employing Agency		Work Address
Phone Number	Fax	Email Address
Name – Backup Security Officer (Last, First MI)		Title
Employing Agency		Work Address
Phone Number	Fax	Email Address

I have read the client confidentiality regulations covered by state policy and federal/state statutes and understand their relationships to authorizing access to client information. I will ensure such confidentiality in accordance with Wis. Stat. §§ 49.81 and 49.83.

User Agreement for Access to the Wisconsin Department of Health Services (DHS) Systems
I have a legal and ethical responsibility to protect the confidentially and security of all protected data and information to which I have access via the DHS system application(s). Confidential information may include, but is not limited to: financial information, client/patient identifiable information, or protected health information. This information is protected by state and federal laws. In order to be granted data about DHS clients that we serve, 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 and all applicable policies and laws. I will not re-disclose any information I have accessed unless needed to complete my authorized task and as allowed by law.

I acknowledge the receipt of my IDs and passwords. I understand that passwords are the equivalent of my signature and that I am responsible for their use.

If I know of an actual or attempted privacy or security violation or inappropriate use or disclosure of this data, I will notify my security officer and supervisor.

It is my responsibility to inform my supervisor and security officer in writing when I am leaving employment. When my association ends, I will no longer access confidential information and will not take any confidential information with me.

I understand that my actions in this system may be intercepted, monitored, recorded, copied, audited, inspected, and disclosed to authorized personnel. Any improper use or unauthorized access of this system may result in administrative

disciplinary action and civil and criminal penalties. By signing this form and continuing to use DHS system(s), I consent to these terms and conditions.

By signing this form, I indicate that I am the person named and that I adopt this entry as my legal electronic signature on this document.

SIGNATURE – Security Officer	Date Signed
Name	Title
SIGNATURE – Backup Security Officer	Date Signed
Phone Number	Email Address
SIGNATURE – Backup Security Officer	Date Signed
SIGNATURE – Agency Director	Date Signed