COMMUNITY CONNECT PROVIDER PORTAL ACCESS REQUEST AND CONFIDENTIALITY AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
SFN 1125 (12-2022)

Clear Fields

Employee Name	Date
Request Type (check all that apply) ☐ Master Administrator ☐ Support Administrator ☐ Care Coordinator ☐ Peer Support Specialist	

Agency Name		
Region	Telephone Number	Start Date
Email Address		
Have you previously had access to the Community Connect Provider Portal? (i.e. due to former or current employment with another agency) ☐ Yes ☐ No		

I acknowledge that I will have access to confidential information regarding Community Connect Program participants under the Department of Health and Human Services, Behavioral Health Division. As part of this access, I agree to the following terms and conditions:

- To ensure with all reasonable and effective efforts that the information contained in the portal will be treated as confidential and used and disclosed solely for purposes required or permitted by applicable federal and state laws, rules, and regulations, including, but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records.
- It is my responsibility to understand and comply with applicable federal and state laws, rules, and regulations and the policies of my employer relating to the use and disclosure of Community Connect participant information.
- I will not share my Community Connect Provider Portal username and password with others and will only use the Community Connect Provider Portal solely for purposes specific to my job duties.

ACKNOWLEDGMENT

By signing this agreement, I acknowledge that I understand and will comply with this agreement. I understand violation of this agreement may involve immediate deactivation of my Provider Portal access and DHHS, Behavioral Health Division may refuse to allow continued services.

Employee Signature	Date
Printed Name	

I agree that if the above employee resigns or is terminated, I will notify DHHS, Behavioral Health Division, Community Connect Administrators immediately upon receiving notice in order to deactivate access to the Community Connect Provider Portal.

Supervsior Signature	Date
Printed Name	