Harmony Data System Privacy and Security Agreement for Individual Provider User

As a user of the Harmony Data System (Harmony) and the Department of Health (DOH) IT resources, I understand that I am responsible for adhering to the additional rules listed below:

1. I understand that all consumer information is confidential. I must protect all consumer information and related confidential information made available to me, in all its forms. I must also ensure the protection of information by preventing unauthorized access of confidential information;
2. I understand that my workstation must be in a secure location when in use, and I must sign off from my access to Harmony when I am gone or not in proximity of my workstation;
3. I must only access information about the consumers and programs, respectively, who and which I am responsible for;
4. I will comply with all federal and state laws, regulations, policies and rules, including, but not limited to: (i) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat 1936 (1996), (codified principally at 42 U.S.C. § 1320d-1320d-6); (ii) the HIPAA privacy and security regulations and (iii) the HIPAA Title II Administrative Simplification and Compliance Act provisions governing electronic transactions and code sets, security, unique identifiers and privacy, Pub L. No. 107-105, 115 Stat. 1003 (2001), (codified principally at 45C.F.R. § 160, §162, and § 164);
5. I understand that my Harmony user identification and passwords are non-transferable, confidential and must not be kept unsecured;
6. I understand that I am the only one allowed to use my assigned passwords and Harmony user (e-mail associated to the myAlaska account). If I suspect anyone else has knowledge of my passwords I will report it immediately, no later than 24 hours, to my Harmony Access Coordinator and the Division of Senior and Disabilities Services (SDS) Harmony administrator at DSDSHarmonyHelp@alaska.gov;
7. I must notify immediately, no later than 24 hours, my Harmony Access Coordinator when changes occur with my legal name, affiliation with my current organization, or title; my Harmony Access Coordinator must notify these changes to SDS Harmony administrator at DSDSHarmonyHelp@alaska.gov.

As an **Individual User of Harmony**, I hereby agree, by signing this form, to immediately, no later than 24 hours, notify my Harmony Access Coordinator and SDS Harmony administrator at DSDSHarmonyHelp@alaska.gov of any suspected or actual breach of security, intrusion or unauthorized access, use or disclosure of consumer or related confidential information.

After completing and having this agreement signed by your Harmony Access Coordinator, please scan it entirely and send it to DSDSHarmonyHelp@alaska.gov.

Note: A new Harmony Privacy and Security Agreement for Individual Provider User form will be required if your access is automatically terminated due to 90 days of inactivity.

Provider Agency Information

Name of Provider Agency: _____

Medicaid Billing Number(s) (if applicable; *e.g.* Anchorage – 1234567): _____

Individual Care Coordinator Medicaid Billing Number(s) (if applicable): _____

Address: _____

Please select the type of the Provider Agency (check all that apply):

☐ Care Coordination Agency:

Please select the Role(s) needed:

☐ Care Coordinator Role

☐ CC Data Entry Assistant Role

☐ Personal Care Services Agency

☐ Long Term Care Facility

☐ ADRC

☐ Other:

Please select the Role(s) needed:

☐ Fair Hearings (External) Role

☐ 3rd Party Review Role

Harmony Individual User Information

Printed Name (First, MI, Last): _____

Phone: _____

E-mail: _____

E-mail associated with myAlaska: _____

Title and job function within Provider Agency (reason for Harmony access):

_____

Signature:

Date: _____

Harmony Access Coordinator Information

Printed Name: _____

E-mail: _____

Signature:

Date: _____