

Tuberculosis Ordering and Billing Interface (TOBI) User Security and Confidentiality Agreement

Instructions

Please complete all fields on the form. Return the completed form to DHSWITBProgram@dhs.wisconsin.gov or fax to 608-266-0049. If you do not have a MyWisconsin ID or have additional questions, please contact the TB Program at 608-261-6319.

User information

MyWisconsin ID login (email): _____

User role (check all that apply)

☐ Wisconsin Division of Public Health Staff ☐ Local public health staff ☐ Pharmacy staff ☐ Clinical staff

Organization name: _____

Organization address: _____

City: _____ State: _____ ZIP code: _____

Confidentiality agreement

I understand that the information in this application 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.

By signing this agreement, **I agree to:**

- Comply with the Wisconsin Division of Public Health (DPH) Wisconsin Electronic Disease Surveillance System (WEDSS) Security and Confidentiality Policy, and my organization's standard policies and procedures related to confidentiality and release of personally identifying health information.
- Handle identifying information on clients in a timely, accurate, and confidential manner.
- Limit my TOBI access to secured and authorized locations and computers.
- Carefully and deliberately, safeguard my TOBI user ID and password in accordance with the WEDSS Security and Confidentiality Policy and my organization policies and procedures. I will not use another person's password nor will I disclose my own.
- Hold exported data securely by using protective software such as encryption and passwords.
- Promptly report to my Local Organization Administrator or Local Security Officer any threat to or violation of the WEDSS Security and Confidentiality Policy.
- Ensure my access to the application is revoked upon the end of my employment. If I am aware that I am ending my employment, I must promptly provide my Local Organization Administrator or Local Security Officer and management with the end date of employment. 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 those 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.

By signing this agreement, **I agree not to:**

- Access, use, divulge, copy, release, sell, loan, review, alter, or destroy any 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.
- Copy the database or software used to access the TOBI application.

I have read, understand, and agree to abide by the WEDSS Security and Confidentiality Policy and the above requirements. I understand the Wisconsin Department of Health Services reserves the right to audit, monitor, record and/or disclose all transactions and data sent over this application in a manner consistent with State and Federal law. Any illegal, unauthorized use or modification of this application and its contents is prohibited and may be subject to civil or criminal prosecution under state and/or federal laws. I consent to the monitoring of my access and use of this application. I understand that, if I violate confidentiality requirements, my access to this application can be terminated and I may be subject to penalties imposed by law. In addition, my supervisor and/or owner of provider practice will be notified of the breach of confidentiality and asked to take action appropriate to their organization.

Signature — TOBI user: _____ Date signed: _____

Name — exactly as entered to register MyWI ID (printed): _____

Title: _____ Phone number: _____

Signature — Health officer: _____ Date signed: _____

Name — Print name: _____

Title: _____ Phone number: _____

Remove this TOBI user

Name: _____

Email: _____

Local organization administrators must keep this document on file for all users granted access to this application.