STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

Confidentiality and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Assurance Agreement and State Law Confidentiality Requirements

I, _____ the_____ of
(Name) (Job Title)

_____ understand and will comply to safeguard the use,
(Qualified Provider)

publication and disclosure of information ("protected health information") on all applicants for, and all individuals supported by the Department of Developmental Services who receive Clinical Behavioral Supports or Healthcare Coordination under contract or through a Provider Authorization accordance "with all applicable federal and state law regarding confidentiality, which includes in but is not limited to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E, and Regs. Conn. Agencies – DDS, Section 19-570-5.

Signed,

_____ _____
*Name Date

*Electronic signature: By signing this document, I guarantee this is my electronic signature. I hereby certify that I am authorized to submit these documents on behalf of the organization.

□ I certify that I understand the HIPAA and State Law Confidentiality Requirements

Revised 1/2014