Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

**STATE OF NEW HAMPSHIRE**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

***DIVISION OF PUBLIC HEALTH SERVICES***

***BUREAU OF INFECTIOUS DISEASE CONTROL***

***IMMUNIZATION PROGRAM***

**29 HAZEN DRIVE, CONCORD, NH 03301**
**603-271-4482 1-800-852-3345 Ext. 4482**
**Fax: 603-271-3850 TDD Access: 1-800-735-2964**
**www.dhhs.nh.gov**

## Oath to Maintain Security and Confidentiality
## NH Immunization Section Immunization Events vJune 2019

I understand that through my participation in a state-sponsored immunization event, I may have access to information in various forms (paper or verbal communications, etc.) that identifies individuals and their health information. I understand that this type of information must remain confidential and the identities of the individuals must be protected.

I agree to adhere to the following rules:

- I will not purposefully or inadvertently disclose the identities of individuals who are who are receiving vaccine to other persons, agencies or organizations unless authorized to do so as part of my duties.
- I will not scan or read paper or electronic documents containing protected health information unless it is necessary for my duties.
- I will not permit other people to make copies of paper documents containing protected health information unless it is necessary for my work or unless authorized to do so.
- I will handle all paper documents carefully and I will not leave them open for other people to see or take.
- I will only mail or fax protected health information to locations and fax numbers authorized by the NH Immunization Section.
- I will not email protected health information or provide this type of information through any other means unless the information is encrypted and the method is authorized by the NH Immunization Section.
- I will protect paper documents from physical and mechanical damage.
- I will hold conversations that involve identifying information, including telephone conversations only in confidential work areas unless authorized to do otherwise.
- I will report any possible or suspected unauthorized release (i.e. breach) of protected health information to my immunization event supervisor.

I understand that if I violate any of the above rules, disciplinary and legal action may be taken against me.

Date: _____ Printed Name: _____

Signature: _____

Public Health Network Responsible for this event: _____

***A copy of this form will be retained by the Public Health Network.***