BHD Medical Record Login Request and Agreement

Agency Name: _____

User Full Name: _____

User Email Address: _____

Have you had access to Avatar or ProviderConnect in the past? ○ Yes ○ No

Please select the appropriate program and function (if applicable) below:

User Program:

Access Point
Adult Family Home**
CBRF**
CCS*
Crisis Resource Center
CRS*
CSP
Day Treatment (AODA)
Detox
Medication Assisted Treatment
Outpatient (AODA)
Outpatient (MH)
Recovery House
Recovery Support Services
RSC
TCM
Transitional Residential (AODA)

***User Function (CCS and CRS Only):**

Care Coordinator
Ancillary Provider
IPS Provider

****User Function (Adult Family Home and CBRF Only):**

Case Manager
House Worker
Supervisor

Do you have supervisory responsibilities?

○ Yes ○ No

Type of service provider?

○ Direct ○ Indirect

Rules and Responsibility Agreement

1. Computer resources (hardware, software, supplies, data, etc.) are for authorized business only. I am not permitted to copy software or County data for personal use or for unauthorized installation on any other computer (County or personal).
2. I will not disclose my password to anyone.
3. I will not allow other staff to enter, delete, or update client information on the computer under my BHD login ID, and I will not perform these actions under another person's BHD login ID.
4. I will consult with my supervisor about my responsibilities or any questions regarding computer and information security.
5. I will report any suspicious or non-compliant use of the medical record to BHD Contract Management Department.

I understand and agree to the above lists of rules and responsibilities regarding access to and use of computer resources and computerized information that is accessed through the BHD login ID. I further acknowledge that failure to observe them may result in revocation of my BHD login ID.

User's Signature: _____ Date: _____

Your Agency's Avatar Contact Signature: _____ Date: _____

Please fully complete and sign both forms and send to BHDCredentialing@milwaukeecountywi.gov

Confidentiality Statement

Milwaukee County Behavioral Health Division (BHD) Confidentiality attestation for contracted entities

It is BHD Management's responsibility to inform all employees, volunteers, and contract service agencies of their role in protecting a patient's right to privacy and maintaining the confidentiality of medical/financial information.

Computerized files are to be treated in the same confidential manner as the written medical record. Computerized information shall be accessed only as is necessary to fulfill job requirements. The information contained in the computer should be treated impersonally and not discussed with anyone except as it pertains to job responsibilities. It is imperative that access ID's are kept confidential and that the employee logs out of the computer whenever they are not using it.

The following Wisconsin State Statutes and Federal Regulations protect the patient's right to privacy of medical/financial information and mandate that healthcare facilities ensure that all information is handled in a confidential manner, thereby preventing disclosure to other persons without consent of the patient:

Wis. Stat. § 153.50	Health Care Information (Protection of Patient Confidentiality).
Wis. Stat. § 51.61(1) (n)	Mental Health Act (Individuals who are receiving services for mental illness, developmental disability, alcoholism or drug dependency have the right to confidentiality of treatment records/information.)
Wis. Stat. § 51.30(4)	Mental Health Act (Access to Registration and Treatment Records)
42 CFR Part 2 (ch. 1-2.2)	Federal Regulations (Confidentiality of Substance Use Disorder Patient Records)
Wis. Stat. § 49.81	Public Assistance Recipients' Bill of Rights
Wis. Stat. § 943.70(2)	Offense against computer data and programs. (Imposes legal sanctions regarding maintaining the security of data.)

I have read the above statements on confidentiality of medical/financial information.

I understand my responsibilities in treating medical/financial information as confidential and agree that data accessed through my BHD login ID will be used solely for the purpose stated and will not be divulged in any form to sources outside the department/agency requesting access.

I have received training on the pertinent parts of Confidentiality/HIPAA mentioned above.

User Name (Print):_____

User's Signature:_____ Date:_____

Please fully complete and sign both forms and send to BHDCredentialing@milwaukeecountywi.gov