

**County Indigent Health Care Program
Confidentiality Agreement**

STAFF MEMBER'S NAME (TYPE OR PRINT)	TITLE (TYPE OR PRINT)
COUNTY	Telephone Number
HIDALGO COUNTY, TEXAS	(956) 318-2011

The following agreement exists to ensure confidentiality, integrity, and continuity of information resources. This agreement applies to all information accessed through the Automated Inquiry System (AIS) or Texas Medicaid & Healthcare Partnership (TMHP).

Please read the following agreement thoroughly. Complete, sign, and date this form. Keep a copy for your records. Return the original to the Texas Department of State Health Services, County Indigent Health Care Group Y-990, P O Box 149347 Austin, TX 78714-9347.

I understand and agree that I may receive client-sensitive information from AIS/TMHP.

I understand and agree that I will use only AIS/TMHP to obtain the status of Medicaid eligibility dates in regards to the County Indigent Health Care Program.

I understand and agree that I will use only the assigned County Provider Identifier number to access AIS/TMHP.

I understand the importance of confidentiality and agree to keep any information received confidential.

I agree not to disclose any information to anyone or allow anyone to use this information.

I understand that I am responsible for my actions and the actions of any county staff member who may receive this information and who is under my direct control and supervision.

I understand and agree that in the event of an audit by Health and Human Services Commission (HHSC) and/or Texas Department of State Health Services (DSHS), the County will make available all documentation regarding Medicaid Reimbursement upon request.

I understand and agree that any question concerning the appropriateness of the release of data will be processed according to DSHS policies and procedures for release of open records.

_____ Staff Member's Signature

_____ Date

_____ County Judge Signature

_____ Date