

**APPENDIX 1
OREGON PUBLIC HEALTH EPI USER SYSTEM (Orpheus)
and Orpheus-Linked Databases
ASSURANCE OF CONFIDENTIALITY**

As an employee in the Center for Public Health Practice (CPHP) of the Oregon Health Authority’s Public Health Division (PHD) or an affiliated Local Public Health Authority (LPHA), or as a subcontractor, student, intern, or visiting professional, I understand that I may have access to information, **the confidentiality of which is protected by Oregon law**, about persons with reportable diseases, persons counseled during clinical or prevention activities, study participants or clients of sites involved in our work. This information includes **public health** surveillance records, electronic and paper records of information obtained during an interview or counseling session or **information obtained from other sources**. Information may also come from health care providers, health clinics, drug treatment centers, jails, and other institutions. Confidential information includes but is not limited to names, addresses, telephone numbers, sexual and drug-use behaviors, medical, psychological and health-related conditions, **risk factors**, and treatment, religious beliefs, finances, living arrangements and social history. **By signing this statement, I acknowledge that I understand my responsibility to protect this information and agree to the following:**

- I have carefully reviewed and will remain familiar with all security policies and procedures described in the *Orpheus and Orpheus-Linked Databases Security Policies and Procedures*.
- I will adhere to all security policies and procedures described in the *Orpheus and Orpheus-Linked Databases Security Policies and Procedures*.
- I will access information solely for the purpose of carrying out the duties of my position.
- **I will truthfully log the reason I access any record associated with a disease or disease group that my user settings do not allow.**
- I will not release or make public, except as required by law, individual case information including demographic data and client contacts.
- I will not discuss confidential information with people who are not authorized to know, view or use this information.
- I will not access information or records concerning patients, clients or study participants, or a confidential document, nor ask questions of clients during interviews for my own personal information.
- I will secure confidential information when not in use, before leaving my work station, **and during any transit**.
- **I will securely convey information only to others who are authorized to receive it and only in a secure manner, e.g., secure e-mail.**
- I will adhere to the established procedures for shredding paper documents and deleting electronic files containing confidential information.
- I will immediately report any suspected security breach to the Overall Responsible Party (ORP) or their designee.
- I understand that I am responsible for preventing unauthorized access to or use of my keys, passwords or security codes.
- I agree not to use another person’s password to access information, and I will not disclose my own **password to anyone else**.
- I understand that I am subject to periodic audit of my Orpheus data use activities and investigation of any irregular data use patterns.
- I understand that a breach of security or confidentiality may be grounds for disciplinary action which may include termination of employment or prosecution.

User’s Printed Name _____ Citrix ID number (P or OR #) _____
 User’s Signature _____ Date _____
 User’s E-mail Address _____ Work phone _____
 Export Location (**All Users MUST choose an export location**) _____
 Date of most recent Security & Confidentiality training _____ **Orpheus Tech Team Member** _____

Affiliation (Choose only ONE)					
OHA Employee	Contractor	Student/Intern	Visiting Professional	Tribal Jurisdiction	Local Public Health Authority
Other (please describe) _____					

Overall Responsible Party’s Printed Name (This is *not* the User.) _____
 Overall Responsible Party Signature _____

Check **ALL** program areas (either yes OR no) for this user.

Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Enteric	Hepatitis	Vaccine Preventable	Pertussis	Vector borne	Misc CD e.g., Anthrax	Animal bites	Prion/CJD	MDRO	Opera e.g. COVID	Outbreaks	CIN*	ABCs*
Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	More Information				
Emerging e.g., VALI	Lead	Env Exp	STD	Syphilis	TB	LTBI	HIV/AIDS*					

Put COVID-19 and other pertinent info or need (iPhone, physical fob, fob ID# and expiration date in “More Information” box.

List all jurisdictions (counties) **to which** user will have access: _____

*Requires additional approval from OHA.