

Immunization Practices Improvement Program

**Data Collection Confidentiality Agreement
For Records Abstractor**

I, _____, agree to protect private and confidential data secured during the Immunization Assessment visit and patient chart review for the _____ (hereafter CLINIC).

Further, I,

- a) agree to protect private and confidential data and release individually identifiable data only to those authorized to see it;
- b) fully agree to conduct myself at all times in a manner that will obtain the respect and confidence of all individuals from whom data will be collected and I will not betray this confidence by divulging information obtained to anyone other than authorized representatives of the Minnesota Department of Health.
- c) agree to use collected immunization information for the sole purpose of providing quality improvement information to the CLINIC.
- d) understand that my obligations under this agreement will survive the termination of my IPI assignment; and
- e) understand that failure to comply with the terms of this agreement will be considered a breach of applicable state and federal laws governing health data, and penalties for state employees who commit a willful violation of the Minnesota Government Data Practices Act may include suspension without pay, dismissal or a misdemeanor.

Site visitor/abstractor signature

Date



Immunization Program
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5503, 1-800-657-3970
www.health.state.mn.us/immunize