

RELEASE ASSURANCES FORM
RHODE ISLAND HOSPITAL DISCHARGE DATA
Center for Health Data & Analysis, Rhode Island Department of Health (RIDOH)

I acknowledge that access to the information from the Rhode Island Hospital Discharge Data described below and provided by the Center for Health Data & Analysis, RIDOH, is granted solely upon the condition that I agree to abide by the terms and conditions set forth in this Release Assurances Form (Form).

Requested data files:

Standard public use data file(s) -- Check time periods requested:

Calendar years (January 1 – December 31)

<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input type="checkbox"/> 2002	<input type="checkbox"/> 2003	<input type="checkbox"/> 2004	<input type="checkbox"/> 2005
<input type="checkbox"/> 2006	<input type="checkbox"/> 2007	<input type="checkbox"/> 2008	<input type="checkbox"/> 2009	<input type="checkbox"/> 2010	<input type="checkbox"/> 2011
<input type="checkbox"/> 2012	<input type="checkbox"/> 2013	<input type="checkbox"/> 2014	<input type="checkbox"/> 2015	<input type="checkbox"/> 2016	

Hospital fiscal years (October 1 – September 30)

<input type="checkbox"/> 2000	<input type="checkbox"/> 2001	<input type="checkbox"/> 2002	<input type="checkbox"/> 2003	<input type="checkbox"/> 2004	<input type="checkbox"/> 2005
<input type="checkbox"/> 2006	<input type="checkbox"/> 2007	<input type="checkbox"/> 2008	<input type="checkbox"/> 2009	<input type="checkbox"/> 2010	<input type="checkbox"/> 2011
<input type="checkbox"/> 2012	<input type="checkbox"/> 2013	<input type="checkbox"/> 2014	<input type="checkbox"/> 2015	<input type="checkbox"/> 2016	

Other data file (describe):

Proposed use of requested datafile(s): (Attach pages as necessary)

I agree to comply with the following conditions:

Confidentiality

1. The confidentiality of the Hospital Discharge Data described above will be maintained as required by Chapter 5-37.3 of the Rhode Island General Laws (Confidentiality of Health Care Information Act) and by all federal and state laws and regulations governing confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act, as amended), and by requirements specified by the Institutional Review Board of RIDOH for the protection of human subjects, where applicable.
2. No information from the Hospital Discharge Data described above will be published or disseminated in a form that might permit identification of an individual patient.
3. The Hospital Discharge Data described above will not be transmitted to any other party in a form in which the data are specified at the level of individual hospital discharges, unless the proposed recipient first files a Form with the Center for Health Data & Analysis, RIDOH, covering the data to be transmitted.

4. If and when disposed of, all information provided under this Form will be handled as follows:
 - a) Paper records will be shredded or burned; CDs will be destroyed or returned to the Center for Health Data & Analysis, RIDOH; and
 - b) Computer tapes and diskettes will be completely erased or returned to the Center for Health Data & Analysis, RIDOH.

Attribution

5. No statement shall be made indicating or suggesting that interpretations drawn from the Hospital Discharge Data are those of RIDOH or of the State of Rhode Island, without prior written consent.
6. If cited in a publication or presentation, the source of the data will be acknowledged as the Rhode Island Hospital Discharge Data, Center for Health Data & Analysis, RIDOH.

Cost of Production and Payment

7. The cost of production of the received data is provided below. Payment must be received prior to release of the data. Money orders or cashier's checks are the only forms of payment accepted, made **Payable to "General Treasurer, State of Rhode Island."** Please mail or bring payment to:

Center for Health Data & Analysis
 Rhode Island Department of Health
 Cannon Building, Room 407
 3 Capitol Hill
 Providence, RI 02908

RIDOH uses the United States Postal Service. At my request and for an additional charge, the materials can be shipped overnight via the United States Postal Service. See below for charges.

Cost of Production	\$100 x Number of Years Requested = \$ _____.00	
Regular Mail No additional Cost	\$ 0.00	\$ 0.00
<u>Optional Services</u> Overnight Shipping via United Parcel Service (UPS)	\$20.00	\$ _____.00
Total Payment Enclosed*	Total	\$ _____.00

*Money orders or cashier's checks Payable to "General Treasurer, State of Rhode Island"

Reporting and Mitigating Unauthorized Uses or Disclosures

8. I agree to report any unauthorized use, reuse or disclosure of Hospital Discharge Data to RIDOH within 48 hours of becoming aware of the incident. The report will include the date of the incident; any harmful effects that may or have been caused by the unauthorized use or disclosure; details about the most likely causes of the incident and how it occurred; and a description of the Hospital Discharge Data accessed, used, or disclosed.
9. In the event that RIDOH has reasonable belief that I have used, reused or disclosed Hospital Discharge Data in violation of this Form, RIDOH may, at its sole discretion,

require me to:

- (a) Investigate and report to RIDOH my determinations regarding any alleged or actual unauthorized use or disclosure;
 - (b) Promptly resolve any issues or problems identified by the investigation;
 - (c) Submit a corrective action plan outlining the steps that I will take to prevent future unauthorized use or disclosure; and/or
 - (d) Return or destroy the Hospital Discharge Data received from RIDOH under this Form.
10. I will preserve evidence relating to each incident, including log report data, to be shared with RIDOH within fourteen (14) calendar days of request. I agree to cooperate with RIDOH and other related State and Federal agencies in any investigation into an unauthorized use, reuse or disclosure.

Breach and Penalties

11. I agree to indemnify, hold harmless and defend RIDOH from and against any and every claim, cause of action, obligation, liability, judgment, damage, loss, cost, expense, and fee (including without limitation reasonable attorneys' and court fees) arising out of or relating to my breach of the terms and conditions in this Form.
12. Should I fail to comply with the terms and conditions of this Form, access to the Hospital Discharge Data will be terminated immediately, and all data will be returned to the Center for Health Data & Analysis, RIDOH. I understand that unauthorized use or disclosure of information from confidential records may be punishable, upon conviction, by a fine and/or imprisonment or both, and/or civil penalties as prescribed by law.

Signature_____

Date_____

Name_____

Title_____

Organization_____

Address_____

Telephone_____

E-Mail_____

The information above is maintained by the Center for Health Data & Analysis for the purpose of enforcement of this Form. This information may also be used by the Center for Health Data & Analysis to create a mailing list. The mailing list allows the Center for Health Data & Analysis to send users information such as notices about the release of data and errata when data errors are discovered.

- I do not wish to be included on the Center for Health Data & Analysis mailing list.**

Shipping Information

10. Please specify the address to which I would like the Hospital Discharge Data mailed, if different than above.

Name _____
Title _____
Organization _____
Address _____

Telephone _____
E-Mail _____

Approved by: _____ Date _____
Chief, Center for Health Data & Analysis

Revised 11/2017