State of Alaska * Department of Health & Social Services
Division of Senior & Disabilities Services

Harmony Data System
Privacy and Security Agreement for Individual Provider User

As a user of the Harmony Data System and DHSS IT resources, I understand that I am responsible for adhering to the additional rules listed below:

1. Iunderstand that all consumer information is confidential
2. I will protect all consumer information and related confidential information made available to me in all its forms
3. I must ensure the protection of information by preventing unauthorized access of confidential information
4. I understand that my workstation must be located in a secure location when in use, and I must sign off from my access to the Harmony Data System when I am gone or not in close proximity
5. I will access only information about the consumers and their programs for which I am responsible for
6. I will comply with all federal and state laws, regulations, policies and rules, including (1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat 1936 (1996), (codified principally at 42 U.S.C. § 1320d-1320d-6), (2) the HIPAA privacy and security regulations; and (3) the HIPAA Title II Administrative Simplification and Compliance Act provisions governing electronic transactions and code sets, security, unique identifiers and privacy , Pub L. No. 107-105, 115 Stat. 1003 (2001) codified principally at 45 C.F.R. § 160, §162, and § 164
7. I understand that my Harmony Data System User Identification and passwords are confidential and may not be kept in written form in unsecured areas.
8. I understand that I am the only one allowed to use my assigned passwords. If I suspect anyone else has knowledge of my passwords I will report it immediately, within 24 hours, to my supervisor and the Division of Senior and Disabilities Services administrator
9. I will report to the Harmony Data System Access Coordinator within 24 hours when changes occur with my legal name, affiliation with this organization, or job duties.

I agree to promptly notify my supervisor and the Division of Senior and Disabilities Services administrator of any suspected or actual breach of security, intrusion or unauthorized access, use or disclosure of participant or related confidential information. I understand that I must report this immediately and within 24 hours to the system administrator at DSDSHarmonyHelp@alaska.gov

After completion, scan this entire agreement to DSDSHarmonyHelp@alaska.gov

Name of Provider Agency	Medicaid Billing Numbers (if applicable)
Address of Provider Agency	Individual Care Coordinator Medicaid Billing Number

What type of Agency: (All that Apply)	
☐ Care Coordination Agency	☐ ADRC
☐ Personal Care Services Agency	☐
☐ Long Term Care Facility	☐ STAR Agency
☐ Hospital	

Printed Name: First, MI, Last	Title
Signature of User Applicant	Date
MyAlaska email address	
E-mail	Phone
Describe your job function within your provider agency and explain why you need access to the system:	

Printed Name of Harmony Data System Access Coordinator	e-mail address:
Signature of Harmony Data System Access Coordinator	Phone