CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Exhibit C

Secure File Transfer Protocol Electronic Data Sharing Access Request Form

This form is used to add health care designees who are authorized to access health care records from California Correctional Health Care Services (CCHCS), Health Information Management (HIM) via Secure File Transfer Protocol (SFTP).

Authority:

Penal Code Section 3003(e)(2) requires the department to electronically transmit to the county agency responsible for community supervision the inmate's tuberculosis status, specific medical, mental health, outpatient clinic needs, and any medical concerns or disabilities for the purpose of identifying the medical and mental health needs of the individual.

Requester/User Information: **For County Clinical Patient Record Continuity of Care Access and Use Only**

REQUESTER/USER (PRINT NAME):		**COUNTY NAME**:
TITLE:		**COUNTY DEPARTMENT:**
E-MAIL ADDRESS: (FOR REQUESTER)		**COUNTY PROGRAM:**
TELEPHONE NUMBER:	**DATE OF REQUEST:**	**COUNTY ADDRESS:**

Training Certifications and Agreements:
Requester/User certifies the Training Certifications and Agreements have been successfully completed and acknowledges the training is required to be completed annually for each authorized user. Copies of the completed documents are attached to this request.

☐ Information Security Training	☐ Non Re-disclosure Agreement (NRDA)
☐ Privacy Training	☐ Security Awareness User Agreement (SAUA)

By signing this document you certify that you are aware of, understand, and are accountable for complying with CCHCS Information Security and Privacy Policies and will comply with all federal and state privacy laws regarding personally identifiable information ("PII") and protected health information ("PHI") entrusted to you as a user assigned and authorized by your county authorizer. Notice to the County Authorizer: When a health care designee is no longer authorized to access the SFTP site, a notification must be provided to County.SFTP.inquiries@cdcr.ca.gov.

COUNTY REQUESTER/USER (PRINT NAME):	**TITLE:**	**SIGNATURE:**	**DATE:**
***COUNTY AUTHORIZER (PRINT NAME):** Stephen Carter Jr.	**TITLE:** Interim Behavioral Health Director and	**SIGNATURE:**	**DATE:**

***County Authorizer is the person listed on the Memorandum of Understanding**

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**********FOR CCHCS HIM STAFF USE ONLY**********

COMPLIANCE:

System Approver **by signing this form, you certify:**

It is appropriate to grant the requested access to the HIM_EDS SFTP folder.

AUTHORIZATION: SYSTEM OWNER SIGNATURE IS REQUIRED BEFORE ACCESS IS GRANTED

SYSTEM FOLDER OWNER (PRINT NAME):	TITLE:	SIGNATURE:	DATE: