State of Delaware
Department of Health and Social Services
Division of Public Health
417 Federal Street, Dover, DE 19901
Phone: (302) 744-4541 ; Fax: (302) 739-6631

# DelVERS Non-Disclosure Agreement

IMPORTANT! Please read all sections below. If you have any questions regarding this Agreement, please discuss them with your supervisor before signing. You should make a copy of the Agreement for your own records.

As a condition of receiving access to the Delaware Vital Events Registration System (DelVERS), I hereby agree to the following:

1. I understand and agree that this Agreement will continue in force even after the end of my term as a DHSS employee, vendor representative or external data provider.
2. I understand and support the Department's firm commitment to avoid unauthorized disclosure of confidential information.
3. I understand that, in addition to confidential client information, other DHSS information that I have access to is also confidential, including but not limited to personnel information.
4. I agree not to disclose confidential DHSS information unless authorized.
5. I agree to consult with my immediate supervisor or the next level of management prior to disclosure if there is any question concerning the authority to release specific confidential information.
6. I agree to adhere to the requirements of applicable federal and state laws, DHSS policy and the ethical standards of my profession.
7. I agree to safeguard from unauthorized disclosure any passwords or other security devices assigned to me.
8. I understand and agree that all confidential material received in the course of my work with DHSS is the property of the Department and that I will relinquish such material to the Department upon my termination as a DHSS employee, vendor representative or external data provider.
9. I understand that violation of this Agreement or violation of the privacy rights of individuals through unauthorized discussion or disclosure of confidential information makes me subject to civil and/or criminal penalties, as well as DHSS disciplinary action, if appropriate.
10. The Division of Public Health, Bureau of Health Statistics reserves the right to suspend or terminate user ids at any time, without notification.

| Assurances | |
|---|---|
| I, the undersigned, hereby confirm that I have read all the sections above and I understand them. I agree with all of the provisions in this Agreement. | |
| Name: | |
| Signature: | Date: |
| Witness' Signature: | Date: |

| Supervisor's Commitment | |
|---|---|
| I agree to notify the security administrator of any change in this individual's privileges or employment status. | |
| Supervisor's Name: | |
| Supervisor's Signature: | Date: |