DEPARTMENT OF HEALTH & FAMILY SERVICES
DIVISION OF PUBLIC HEALTH
DPH 5701 (07/04)

STATE OF WISCONSIN
Bureau of Health Information and Policy
Health Care Information Section
Ref: Chapter 153, Wisconsin Statutes

Inpatient Discharge and Emergency Department Data Use Agreement

Patient Confidentiality

Chapter 153, Wisconsin Statutes, requires the Department of Health and Family Services to protect the identity of all patients represented in data collected under this chapter. The Bureau of Health Information and Policy (BHIP) omits from their data files all direct personal identifiers, as well as characteristics that might lead to the identification of individual patients. Any effort to determine the identity of any person or to use the data for any purpose other than analysis and aggregate statistical reporting violates Chapter 153, Wisconsin Statutes, and the conditions of this Data Use Agreement (DUA). By virtue of this DUA, the undersigned agrees that no attempts to identify individual patients will be made and that, in any event, such information will never be released or published.

Civil Liability

Any person, organization, or corporation violating patient confidentiality provisions under s. 153.50 Wisconsin Statutes, or Administrative Rules promulgated under s. 153.75 (1) (a) Wisconsin Statutes, is liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

Penalties

Whoever intentionally violates data release and data re-release provisions under s. 153.45(4) and (5) Wisconsin Statutes, Patient Confidentiality Provisions under s. 153.50 Wisconsin Statutes, or Administrative Rules promulgated under s. 153.75(1)(a) Wisconsin Statutes, may be fined not more than $10,000 or imprisoned for not more than nine months or both.

↓ Print or Type Name of Your Organization Here ↓

The undersigned assures the following with respect to Bureau of Health Information and Policy data files:

- I and all other persons under my direct supervision, who will use BHIP data in the organization specified above, agree to sign and have notarized DUA(s) and return the original DUA(s) to BHIP before any data are released. I understand that DUA(s) shall be renewed annually, based on the filing date of the previous DUA.
- In the event that BHIP data are purchased, repackaged using a proprietary software product, and re-released to subsequent users, I agree to 1) obtain prior written approval from BHIP, 2) provide BHIP with the names and addresses of all subsequent users, and 3) submit to BHIP the original, signed, and notarized DUA(s) for all subsequent users who will access raw, non-aggregated, patient-level data files.
- I will not release or permit others to release any data that identify persons, directly or indirectly. Specifically, all data, regardless of media, will be secured in a locked location or maintained only on isolated, secure systems.
- I will not release or permit others to release the data files or any part of them to any person who is not under my direct supervision, except with the approval of the BHIP.
- I will not attempt to link or permit others to attempt to link the patient-level records of individual patients in BHIP data files with personally identifiable records from any other source, including but not limited to employment, insurance, or zip code records and/or databases.

Data Use Agreement: Inpatient Discharge and Emergency Department

- I will not attempt to use nor permit others to attempt to use BHIP data files to learn the identity of any person represented in any other data file, including but not limited to employment, insurance, or zip code records and/or databases.
- I will make no statement or permit others to make statements indicating or suggesting that interpretations drawn from BHIP raw data are those of the data sources or of the BHIP and its staff.
- I will acknowledge in all reports based on these data that the data source is the Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services, State of Wisconsin.
- In consideration of any data received, I agree and promise that, if any data that identify an individual physician or physicians are re-released, the physician's written comments to the BHIP shall accompany the data, if any comments exist.
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Print or Type Name of Data User		Data User's Title
Your Organization / Affiliation		
Address		
City	State	ZIP Code
Telephone		E-mail
Fax		
Name of Vendor / Organization (if not BHIP) from whom you are receiving Wisconsin data (if applicable)		Telephone Number

My signature indicates that I agree to comply with Wisconsin Statutes and the requirements stated in this agreement. The Data User must sign this document in the presence of a Notary.

SIGNATURE - Data User   Date Signed

Notarization

Subscribed and sworn to before me this

______ day of ______________, 20____

Notary Public   (notary seal)

Return this agreement to:
Wayne Bigelow
CHSRA
610 Walnut Street
Madison, WI 53726
608-263-4846

My commission expires on ____________