Confidential Information Disposition Agreement

The purpose of this Confidential Information Disposition Agreement is to be a checklist and agreement between the below referenced Business Associate and CareOregon, Inc., or its below identified subsidiary ("Plan Sponsor"), to document the proper handling of Plan Sponsor's member PHI and confidential data, regardless if physical or electronic format, (PHI and confidential data collectively referred to as "Confidential Information") that Business Associate or its subcontractor(s), have received, created, maintained, or transmitted on behalf of Plan Sponsor, throughout the period of the parties' contractual relationship identified below. Disposition of Confidential Information is in accordance with the below referenced contract and the Health Insurance Portability and Accountability Act as amended.

IDENTIFICATION OF CONFIDENTIAL INFORMATION

Plan Sponsor:
Business Associate:
Contract Name:
Initial Date of Contract:
Date of Contract Termination:
Description of Services Performed by Business Associate:

What Confidential Information has been in the possession of the Business Associate and its subcontractors since the beginning of the Contract?

Did the Business Associate *create or collect additional* Confidential Information that *was not given to Plan Sponsor*? ☐Yes ☐ No

If yes, describe the data:

What Confidential Information has Business Associate received during the Contract term?

DATA MANAGEMENT

Business Associate, will manage the return, retention, or destruction of Confidential Information. A combination of return, retention, or destruction of data is acceptable. Select all that apply:

☐ Option 1: Return of Plan Sponsor Confidential Information

All methods for returning data must be secure and acceptable to Plan Sponsor Information Technology Security.

Business Associate will return to Plan Sponsor the following PHI created, received, maintained, or transmitted by or on behalf of Plan Sponsor.

Business Associate will return to Plan Sponsor the following confidential data created, received, maintained, or transmitted by or on behalf of Plan Sponsor.

What method will the Business Associate use to return the Confidential Information?

☐ **Electronic:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

☐ **Paper:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

☐ Option 2: Retention of Plan Sponsor Confidential Information

Business Associate will retain the following PHI and/or confidential data:

☐ **Electronic:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

☐ **Paper:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

Reason(s) Business Associate needs to retain the PHI and/or confidential data:

Date PHI and/or confidential data will no longer be retained by the Business Associate, in accordance with any applicable contract terms, laws, or regulations .:

☐ **PHI:** mm/dd/yyy

☐ **Confidential Information:** mm/dd/yyy

☐ Option 3: Destruction of Plan Sponsor Confidential Information

Business Associate will properly destroy the following Plan Sponsor PHI and/or confidential data:

☐ **Electronic:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

☐ **Paper:** Is this for ☐ PHI, ☐ Confidential data, or ☐ both?

Reason it is acceptable for the Business Associate to destroy this data is:

☐ **The data is a copy; Plan Sponsor has the original**

☐ **The data is more than ten years old and no longer needs to be retained**

☐ **Other:** Contractual obligations of data destruction upon contract termination

Confirmation of Destruction **(complete after data has been destroyed)**

Date of Destruction: mm/dd/yyy

Indicate Method(s) of Destruction:

☐ **Physical destruction of drive/electronic media**

☐ **Shredding**

☐ **Other (i.e., electronic destruction):**

ATTESTATION

Business Associate
By signing below, I attest that I am authorized to bind the Business Associate; that Business Associate's Disposition of Confidential Information complies with all applicable contract terms, laws, and regulations; and that the above information is true and accurate.

Signature:_____ Date:_____

Print Name:_____ Title:_____

Plan Sponsor
By signing below, Plan Sponsor's representative has worked with the Business Associate for the disposition of Confidential Information in accordance with the above referenced contract and applicable CareOregon policies.

Signature:_____ Date:_____

Print Name:_____ Title:_____