

ATTACHMENT D

**STATE OF GEORGIA
THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH
2 PEACHTREE STREET, N.W.
ATLANTA, GEORGIA 30303-3159**

**CONFIDENTIALITY STATEMENT
FOR SAFEGUARDING INFORMATION**

I, the undersigned, understand and, by my signature, agree to comply with Federal and State requirements regarding the safeguarding of the Department of Community Health/State Health Benefit Plan information in my possession, including but not limited to information that is obtained electronically from the Fiscal Agent, vendors, or any other entity or individual while performing contractual services with or for the Department of Community Health, its agents or contractors.

Individual's Name: (typed or printed): _____

Signature: _____ Date: _____

Telephone No.: _____

Company or Agency Name and Address: _____

