

ATTACHMENT E

**DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATE OF DESTRUCTION OF CONFIDENTIAL DATA**

I, _____ (Name of Custodian), hereby certify the following to be true and correct:

I. I am employed by _____ (Name of User) as a(n) _____ (occupation).

II. Pursuant to the attached Data Use Agreement (“DUA”) between the DEPARTMENT OF HEALTH CARE SERVICES (“DHCS”) and _____ (Name of User), I received and acted as custodian of the data described in Attachment A of the DUA.

III. ☐ The purpose for receiving some of the data described in Attachment A has been met.

OR

☐ The purpose for receiving some data described in Attachment A has been met. That data is specified as follows:

IV. In compliance with Section 10 of the DUA, the data indicated in Paragraph III above has been destroyed by _____ (method of destruction) on _____ (date of destruction).

Signature of Custodian

Date