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| DSHS POLICY 15-2; DSHS POLICY 2.2.1**OATH OF CONFIDENTIALITY** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree not to divulge, publish, or otherwise make known to unauthorized person ( NAME OF PERSON TAKING OATH (PLEASE PRINT OR TYPE)the information obtained by my access (in any form) to the Mental Health – Consumer Information System (MH-CIS). \_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPLICANT INITIALSI understand that this Oath is valid only if it carries my own signature and the required signatures of the authorized representatives qualified to grant access to the MH Intranet site. I further recognize that a request for or receipt of confidential information under pretense may subject me to criminal liability which is punishable as a gross misdemeanor (RCW 71.05.440). \_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPLICANT INITIALSI recognize that unauthorized release of confidential information may subject me to civil liability under the provisions of state law, and triple the damages of actual damages sustained. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPLICANT INITIALS**\*An authorized person is an individual who can produce a valid, signed copy of this Oath showing that they have been approved for access to the MHD-CIS. Any individuals who are unable to do this are considered unauthorized.** |
| 1. SIGNATURE OF PERSON TAKING OATH | 2. DATE |
| 3. EMAIL ADDRESS OF PERSON TAKING OATH | 4. TELEPHONE NUMBER OF PERSON TAKING OATH |
| 5. NAME OF WITNESS(PLEASE PRINT) | 6. EMAIL ADDRESS of witness | 7. DATE |
| 8. SIGNATURE OF WITNESS | 9. TELEPHONE NUMBER OF WITNESS |
| **SUBCONTRACTING AGENCY ONLY** |
| 10. subcontracting agency name | 11. subcontracting agency id number |
| 12. authorizing representative (please print)  | 13. signature | 14. telephone number |
| **CONTRACTING USE ONLY** |
| 15. cONTRACTOR NAME (PLEASE PRINT) | 16. contractor id | 17. TELEPHONE NUMBER |
| 18. contractor email address | 19. SIGNATURE | 20. aPPLICANTS LOGIN ID |
| 21. ASSIGN AS A LOCAL ADMINISTRATO? IF YES, APPLICATION MUST COMPLETE THE “LOCAL ADMINISTRATOR AGREEMENT”.□ YES □ NO |
| **DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS) USE ONLY** |
| 22. AUTHORIZING REPRESENTATIVE (PLEASE PRINT) | 23. SIGNATURE | 24. Date |

**Please Note: This oath expires one year after access is authorized, a new oath will need to be submitted for continued access.**

**Entity Requirements**

* + - You must complete an Oath of Confidentiality [https://fortress.wa.gov/dshs/hrsamhd/pages/‌Sign\_Up\_Main.asp](https://fortress.wa.gov/dshs/hrsamhd/pages/Sign_Up_Main.asp). When completed, fax the signed Oath of Confidentiality to your local Administrator.
		- Allow 2-3 working days for your local Administrator to create your account with appropriate access options and send you your User ID and password.
		- Allow another 2-3 working days for your local Administrator to forward a copy of your signed Oath of Confidentiality to MHD Headquarters for review, filing, and account activation.