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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 INITIALS  I 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 INITIALS  I 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.