

St. Clair County Community Mental Health Authority

Confidentiality

I have read and understand the St. Clair County Community Mental Health policy, Release of Case Record Information, #03-002-0030. I understand that recipient information is confidential and access to and release of the information will be in accordance with this policy, the Mental Health Code, Administrative Rules, and HIPAA.

If I am provided with electronic access to OASIS as part of my placement or internship, I understand I am only to access records of those individuals I am serving and only to the extent required, as approved by the Program Supervisor and/or my field instructor. I understand all OASIS information is confidential. I agree not to share information with anyone not authorized to receive it and to refrain from accessing any information I am not authorized to access.

Student Name (please print): _____

Student Signature: _____

Date: _____

**Please send this completed form to Stephanie Shank at
Administration for Student Placement file.**