JOES KIDS
ACHIEVEMENT PLACE

Student Intake Form

Name:		**School:**	
Address:		**Graduation Date:**	
		Field of Interest:	
		Applying to Therapy?	Yes ☐ No ☐
Phone:		**Here for:**	Observation ☐ WCS Intern ☐ Fieldwork ☐
Email:		**Scheduled hours:**	

Confidentiality Agreement

The Federal Health Insurance Portability and Accountability Act (HIPAA), the State of Indiana Confidentiality of Medical Information Act and related laws and regulations were established to preserve the confidentiality of medical and personal information, and to specify that such information may not be disclosed except as authorized by law or unless authorized by the patient. These privacy laws and regulations apply to all Joe's Kids personnel, including students. All students are required to agree and sign this confidentiality statement.

I understand that, as an observer for clinical education purposes, I may see or hear confidential information such as medical information about a patient, verbal discussions about patient care, and electronic communications that include confidential patient information.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of this information. I will not access, use, or disclose any confidential information outside of my clinical education experience at Joe's Kids. I understand that I am required to immediately report any information I may have about the unauthorized access, use, or disclosure of confidential information to the Executive Director at Joe's Kids.

I understand that if I breach any provision of this Agreement, I may be subject to civil or criminal liability.

_____
Student Name (please print)

_____ _____
Student Signature Date

Parent signature is also required for students under 18 years of age:

_____
Parent Name (please print)

_____ _____
Parent Signature Date