

CONFIDENTIALITY AGREEMENT

As an employee / volunteer who is involved in the evaluation and monitoring of the quality of care rendered to our clients, I recognize that confidentiality is vital. I also understand that preservation of this confidentiality is the policy of this Agency.

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with the activities of the Agency. I will make no voluntary disclosures of such information except to persons authorized to receive it by the agency. I understand the agency is entitled to undertake such action as is deemed appropriated to ensure that this confidentiality is maintained.

My signature below indicates that I have been informed of the Company's Health Insurance Portability and Accountability Act (HIPAA) compliance plan and policies.

In efforts to maintain these policies and overall patient confidentiality, I guarantee by my signature below that any data input on my personal computer concerning or related to the client or the company, will be password protected and not accessible to anyone, other than myself. If I use an office computer, no other person will use my computer password nor will anyone have access to my password or its use.

Any breach of this agreement may result in termination.

Please Print Name

Employee

Date

Company Representative

Date

Title