

## EMPLOYEE/VOLUNTEER CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_, understand that in the performance of my  
(Employee/Volunteer Name)

duties for \_\_\_\_\_, I may have access to medical,  
(County Aging Provider Agency Name)

insurance, and other confidential/personal information. I agree to restrict my use of such information to the performance of my duties. I will not discuss the service recipient's name, or otherwise reveal or disclose information pertaining to the service recipient, except when required by our agency management, federal and/or state representatives, or the AAA. I hereby acknowledge my obligation to respect the service recipient's privacy and the confidentiality of the information pertaining to the service recipient. I agree to exercise good faith and integrity in all dealings with the service recipient and their personal information in the performance of my duties as a representative of \_\_\_\_\_.

(County Aging Provider Agency Name)

I also understand that any unauthorized use or disclosure of information pertaining to the service recipient may result in my immediate suspension and/or dismissal and may subject me to civil liability for breaching the service recipient's right to privacy.

\_\_\_\_\_  
**Employee/Volunteer Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agency Representative Signature**

\_\_\_\_\_  
**Date**