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 _____. I also understand that any unauthorized
(County Aging Provider Agency Name)

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**