HIV/CONFIDENTIALITY STATEMENT

I, the undersigned understand the importance of observing strict confidentiality policies. Therefore I agree not to discuss or release any information obtained within the agency regarding any client, their medical record or any client's condition with any individual not directly associated with nor with employees who are not directly associated with that client's records will only be done with proper authorization as/or in accordance with established agency policy for release of information.

In the event you are made aware that your patient is HIV positive you cannot disclose this information to any other individual. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as permitted by law. Any unauthorized disclosure is a violation of State law and may result in a fine or jail sentence or both. General authorization for the release of medical or any other information is not sufficient authorization for further disclosure.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the disciplinary procedure up to and including possible IMMEDIATE DISMISSAL from employment at .

My signature below supports this statement.,

Name (Print) _____

Signature: _____ ***SIGNHERE)*** Date: _____