



CONFIDENTIALITY AGREEMENT

I, _____, understand that any personal consumer, family or medical information obtained through service provision, observation of meetings, or records is confidential and protected by Federal and State regulations (42 CFR, Part 2, RCW 71.05.390). Under no circumstances will I disclose consumer names or any other personal or medical information obtained in the course of my duties with the Center for Independence North Sound to anyone unless a signed and dated release of information form authorizes me to do so.

If I am authorized to release consumer information, I declare that I have read the confidentiality policies of the Center for Independence North Sound and agree to follow such policies.

If I am participating in a meeting or home visit as part of a team, I understand that I may be asked to leave and I agree to comply.

Employee Signature

Date

Witness/CFI Director Signature

Date