

WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

CONFIDENTIALITY STATEMENT

As an employee of Whitman County I, _____ (print), acknowledge that I have a legal responsibility to maintain the confidentiality of employee and client information, records and health care information. I, therefore, agree to the following:

I understand that employee/client information records and health care information compiled, obtained, maintained or reviewed by me in the course of my duties may be confidential. I agree not to disclose or otherwise make known to any unauthorized persons any information regarding confidential information, unless so directed by my supervisor.

No privileged information, whether written or oral, will be shared with my family members and/or friends.

I understand that I am not to read information, records and health care information concerning clients and case reports or any other confidential documents for my own personal information unless for the purpose of enabling me to perform my assigned duties.

I will, whenever possible and in the course of my duties, discuss confidential information in a location where privacy is assured. I will be mindful that these discussions do not take place in hallways, elevators, bathrooms or other public areas.

All documents concerning employee/client confidential information will be kept in a secure location when not in use.

When working on computer files, I will use passwords, screensavers and other protective steps to prevent access to confidential files and databases.

I will not disclose my computer password or voice mail security code to unauthorized persons.

I understand that a breach of security or confidentiality may be grounds for disciplinary action, which may include termination of employment.

Employee Signature

Date

Supervisor's Signature

Date

Copy to Employee File

Original to HIPAA File

WCLIB #24