



CONFIDENTIALITY STATEMENT

I understand that in the performance of my duties, I may have access to certain sensitive/confidential information about residents. All information that I obtain related to individual residents, clients, guests, family or staff of the Ombudsman Office or facility, whether verbal or written, may not be mentioned or released for any reason other than through the conduct of my assigned volunteer responsibilities.

I will, to the best of my ability, take all necessary precautions to maintain the confidentiality of all Individually Identifiable Health Information. This includes obtaining client authorization for the release of health information as required by federal and state law. I will limit the release of any health information in the record to the relevant purpose for which disclosure is sought. This includes not discussing any aspect of this information unless in the context of appropriate business transactions. This also includes proper storage, retention and disposal of Individually Identifiable Health Information.

I understand that the wrongful disclosure, modification or destruction of Individually Identifiable Health Information at any time may result in termination of my volunteer status, criminal and/or civil penalties. The penalties include liability for actual damages caused by the wrongful disclosure.

Printed Name _____ Date _____

Signature _____

Witness _____ Date _____

Volunteer Coordinator or Manager