BEHAVIORAL HEALTH NETWORK, INC.
ADMINISTRATIVE SERVICES
417 Liberty Street, Springfield, MA 01104
Tel. 413-747-0705 * Fax. 413-732-7075

CONFIDENTIALITY AGREEMENT

1. I recognize and accept that a major responsibility of mine in working for/with a program of Behavioral Health Network, Inc. is to protect the rights of confidentiality held by all the clients served by the program.

2. I will at all times protect the client records kept by the program from unauthorized review by any and all unauthorized persons, including but not limited to other agency personnel, visitors and client family members and friends.

3. I will at all times abide by a client's wishes with regard to release or provision of client information.

4. I shall, at all times, be mindful of, and protect, our clients' right to confidentiality in my conversations, correspondence, and notes, wherever I may be.

5. I understand that I will be held accountable for those commitments by the leadership of the program, and by my co-workers. I will expect my co-workers to be similarly accountable.

_____
Print Name (Employee)

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

Email Form to HR