

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

**VOLUNTEER/SERVICE PROVIDER**  
**CONFIDENTIALITY STATEMENT**

As a volunteer, service provider, or authorized visitor of Whitman County you have the responsibility of maintaining the confidentiality of all health-related client or employee information or records. By signing this statement you agree to the following:

I understand that employee/client information, records and health care information compiled, obtained, maintained or reviewed or observed 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 Whitman County.

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 data, 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 terminating my relationship with this agency.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Copy to Recipient**