

STATEMENT OF CONFIDENTIALITY

I _____, a paid attendant / employee of _____, consumer / employer, fully understand the importance of confidentiality. I agree not to discuss with anyone my employer's disability, or the nature of the services I provide to my employer, under any circumstances, other than those specified and directed by my employer or as otherwise allowed by applicable law or the terms and conditions of the CDS program. I understand that I have an obligation to comply with the Health Insurance Portability and Accountability Act (HIPAA). I further understand that breach of this agreement constitutes grounds for immediate termination from employment by the consumer/employer.

I have read the confidentiality statement and understand the content of this statement.

Signature of Attendant/Employee

Date