PLEDGE OF CONFIDENTIALITY

This is to certify that I, _____, an employee, student, volunteer, clergy, physician, Board Member of the Capital District Health Authority (CDHA), understand that any information (written, verbal or other form) obtained during the performance of my duties must remain confidential. This includes all information about patients, clients, families, employees and medical staff members, as well as any information otherwise marked or known to be confidential.

I have read and understand the information provided with this sheet.

I understand that any unauthorized release or carelessness in the handling of this confidential information is considered a breach of the duty to maintain confidentiality.

I further understand that any breach of the duty to maintain confidentiality could be grounds for immediate dismissal and/or possible personal liability in any legal action arising from such breach.

Signature of Employee/Student/Volunteer/Clergy