



**Confidentiality Oath, Ethics Policy, & Protected Health Information (PHI) Policies**

Employee Name: \_\_\_\_\_  
(Please print)

**Confidentiality Oath**

This is to acknowledge that I have read and understand The Center's confidentiality policy (policy # 8.00).

I understand that the information that I will review in the medical record is confidential and is protected under the Rhode Island Mental Health Law 40.1-5 and Rhode Island Law 40.1-24, and the Federal Regulation 42 C.F.R. part 2.

I will direct any questions I may have to my supervisor or the Director of Performance Improvement Department.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Code of Ethics and Conduct Guidelines**

This is to acknowledge that I have read and understand The Center's Code of Ethics and Conduct Guidelines (policy #8.02).

I understand that violation of the guidelines set forth in The Center's Code of Ethics and Conduct will result in disciplinary action, up to and including termination of employment.

I will direct any questions I may have to my supervisor or my Program Director.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Protected Health Information (PHI)**

This is to acknowledge that I have read and understand The Center's policies on Protected Health Information (policy #'s 4.03, 4.04, 4.05, 8.00). Any questions I may have can be directed to Rob Walsh, Director of Performance Improvement, at (401)-727-6477. I understand that violation of the guidelines set forth in the PHI policies will result in disciplinary action, up to and including termination of employment.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_