Peachtree Family Psychiatry Clinic
1720 Peachtree Street NW, Suite 320
Atlanta, Georgia 30309

CONFIDENTIALITY AGREEMENT

I, _____, agree with the following statements:

I have read and understood Peachtree Family Psychiatry Clinic's Privacy Policy.

I understand that I may come in contact with confidential information during my time at **Peachtree Family Psychiatry Clinic.** As part of the condition of my work with **Peachtree Family Psychiatry Clinic.** I hereby undertake to keep in strict confidence any information regarding any client, patient, employee or business of **Peachtree Family Psychiatry Clinic** or any other organization that comes to my attention while at **Peachtree Family Psychiatry Clinic**. I will do this in accordance with the **Peachtree Family Psychiatry Clinic**'s privacy policy and applicable laws, including those that require mandatory reporting.

I also agree to never remove any confidential material of any kind from the premises of **Peachtree Family Psychiatry Clinic** unless authorized as part of my duties, or with the express permission or direction to do so from **Peachtree Family Psychiatry Clinic.**

_____
(Print Staff Name)

_____
(Signature of Staff)

_____
(Signature of witness)

Dated this _____ day of _____, 2_____