

CONFIDENTIALITY AGREEMENT

Volunteers and members of FLUX will have access to confidential information, both written and oral, in the course of their job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently a volunteer or member of the organization. Any other disclosures may only occur at the direction may only occur at the direction of the President or by patient authorization.



I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties.

I will request, obtain or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties.

I will take reasonable care to properly secure confidential health information on my computer and will take steps to ensure that others cannot access such information.

I will document all disclosures of confidential health information, including those authorized by clients of FLUX or AIDS Healthcare Foundation and any accidental disclosures, in the appropriate client's file.

I have read and understand FLUX's policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my duties including, but not limited to, financial, technical, propriety information of the organization, current or future business plans and models and personal and sensitive information regarding patients, employees, guests, volunteers and vendors, regardless of whether such information is designated as "Confidential Information" at the time of its disclosure. I understand that inappropriate disclosure or release of said information is grounds for termination.

It is understood and agreed to that the below identified discloser of confidential information contained within any FLUX United meeting, event, and/or any gathering must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under patent and/or trade secret laws, it is agreed that:

I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. No other representations concerning the legal effect of this document have been made to me. This agreement shall not be modified orally.

Print Name

Signature

Date



WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH FLUX and AIDS Healthcare Foundation, including but not limited to, any risks that may arise from any activity or negligence on the part of the persons or entities being released, resulting in any physical, mental or psychological injury (including paralysis and death), illness, damages, or economic or emotional loss I may suffer because of my participation in this group.

In consideration of my application and permitting me to participate in the group, I hereby take action for executors, my administrators, heirs, next of kin, successors and myself.

I am voluntarily participating in the group and I assume all related risks, both known or unknown to me, of my participation in the group.

I have no physical or mental condition, which, to my knowledge, would endanger others or myself if I participate in this group, or would interfere with my ability to participate in the group. I also agree to abide by any established rules or regulations while engaged in this group. I understand while participating in this group, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose.

I agree to hold FLUX and AIDS Healthcare Foundation, their volunteers, members, officers, agents, servants, and employees harmless from any and all claims, including attorney's fees or damage to my personal property that may occur as a result of my participation in the organization, including travel to, from and during the group activities. If I need medical treatment, I agree to be financially responsible for any costs incurred. I am aware and understand that I should carry my own health insurance. I am 18 years or older. I understand the legal consequences of signing this document, including (a) releasing FLUX and AIDS Healthcare Foundation, their volunteers, members, officers, agents, servants, and employees from all liability, (b) promising not to sue FLUX or AIDS Healthcare Foundation, their volunteers, members, officers, agents, servants, and employees, (c) and assuming all risks of participating in the group.

I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. No other representations concerning the legal effect of this document have been made to me. This agreement shall not be modified orally.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Print Name

Signature

Date