



CONFIDENTIALITY AGREEMENT

I understand that I am legally prohibited from discussing patient information other than with current Castlewood staff; including any past, present and prospective clients.

I understand that this is a condition of my presence at Castlewood Treatment Center and that any breach of client confidentiality may result in immediate legal action by Castlewood Treatment Center.

Signature

Date

Parent/Guardian Signature (If Applicable)

Date

Facility Witness's Signature

Date