



Privacy Act Provision Statement of Understanding

Please sign and print your name and return to the office of Graduate and Extended Studies.

I understand that by virtue of my employment with East Stroudsburg University, I may have access to records, which contain individually identifiable confidential information. I acknowledge and fully understand that the willful or intentional disclosure by me of this information to any unauthorized person places me in violation of the privacy act of 1974 and could subject me to criminal and civil penalties as imposed by law. I further acknowledge that such willful or intentional unauthorized disclosure also violates the University's policy and could constitute just cause for disciplinary action including termination of my employment regardless of whether criminal or civil penalties are imposed.

Employee name (printed)

Witness name (printed)

Employee signature

Witness signature

Date

Date

Department