STATEMENT OF CONFIDENTIALITY

1. I understand that during my association with SRH I may have access to information and material relating to patients, credentialed staff, other hospital personnel or other confidential information. At all times, this information will not be accessed, used or disclosed for purposes other than for which the information is intended and for which I am authorized.

2. All reasonable measures will be taken by me to ensure that sensitive information (personal, patient and corporate) is collected, used and disclosed only in circumstances necessary by law and authorized for patient care, research, or education, or as necessary in the conduct of the business of SRH and in compliance with the *Personal Health Information Protection Act, 2004.*

3. I shall not remove confidential information from SRH premises except when it is necessary for me to do so for a legitimate purpose related to my association with SRH. I shall not remove patient records or other personal health information from the SRH premises unless I am authorized to do so by the Chief Privacy Officer or his or her delegate. If I am required to remove information from SRH premises, I will take all necessary measures to safeguard this information.

4. I understand that my information system user ID is equivalent to my signature, and will take all reasonable steps necessary to safeguard my password from disclosure to others. If I have any reason to believe that the security of my user name and/or password is at risk or has been compromised, I will immediately notify my supervisor and contact the Information Services department for reassignment of a new password.

5. I understand that the use of my information system access will be strictly limited to accessing information on a need-to-know basis for direct patient care or performance of one's duties. I will not attempt to access any unauthorized information including information about myself, my family, friends, colleagues, neighbours or any other person whose information is not required to perform my work duties.

6. I understand and agree that in order to deter the unauthorized access, use or disclosure of personal health information in the Hospital's electronic information systems, SRH will conduct audits to ensure compliance with privacy practices and policies on the use of my information systems access. I understand and agree that I will be accountable for access to any records where I do not have a need to know.

7. If I believe that there may have been a breach of confidentiality, if I have committed a breach of confidentiality or if I believe there may have been a breach of SRH's privacy policies or procedures, I agree to notify the Hospital's Privacy Office at (416) 284-8131 x 4302 or privacy@rougevalley.ca and my supervisor at my first reasonable opportunity.

8. I understand that a breach of confidentiality includes, but is not limited to, accessing personal health information without authorization to do so. Confirmed breaches may result in any or all of the following:

- Deactivation of my information systems access,
- Discipline including termination of employment, hospital privileges, hospital association or contractual relationship
- A report to my regulatory college where applicable
- A report to the Information and Privacy Commissioner where applicable
    - I understand that the Information and Privacy Commissioner of Ontario may investigate violations and has the authority to fine individuals $100,000 and corporations $500,000 for any violations of the privacy legislation in effect in Ontario.

9. I understand and agree to abide by this agreement, and I understand that this Agreement remains in force, even if I cease to have an association with SRH.

10. I have had the opportunity to review this Agreement and any questions I may have were answered to my satisfaction. I understand that if at any time I have questions about this Agreement or about my duties regarding privacy and confidentiality, I am to speak to my immediate supervisor or the Privacy Office.

I, (first and last name)_____, agree that I have read and will observe and comply with the Scarborough and Rouge Hospital (SRH) privacy policy, procedures and Statement of Confidentiality.

_____ _____

Signature Date (dd/mm/yyyy)

*** Please print clearly, all fields are REQUIRED.***

User name: _____

Employee Number: _____ (if applicable)

Site: _____

Department/Unit: _____

SRH Work Email: _____ (if applicable)