SHN
SCARBOROUGH HEALTH NETWORK

STATEMENT OF CONFIDENTIALITY

1. I understand that during my association with SHN, 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. I will take all reasonable measures to ensure that sensitive information (personal, patient and corporate) is collected, used and disclosed only in the circumstances necessary by law and authorized for patient care, research, or education, or as required in the conduct of the business of SHN and compliance with the *Personal Health Information Protection Act, 2004.*

3. I shall not remove confidential information from SHN premises except when I must do so for a legitimate purpose related to my association with SHN. I shall not remove patient records or other personal health information from the SHN premises unless authorized by the Chief Privacy Officer or their delegate. If I am required to remove information from SHN 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 I 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 username 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 the 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, SHN 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 SHN's privacy policies or procedures, I agree to notify the Hospital's Privacy Office at 416-495-2400 x5745 or privacy@shn.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. 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 the following applies:
        - An individual guilty of committing an offence under PHIPA can be liable for a fine of up to $200,000 or up to one year in prison, or both. An organization or institution can be liable for a fine of up to $1,000,000.
        - If a corporation commits an offence under PHIPA, every officer, member, employee or agent of that corporation found to have authorized the offence or who had the authority to prevent the offence from being committed but knowingly refrained from doing so can also be held personally liable.

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 SHN.

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 I have questions about this Agreement or my duties regarding privacy and confidentiality, I am to speak to my immediate supervisor or the Privacy Office at any time.

I, ____, agree that I have read and will observe and comply with the Scarborough Health Network (SHN) privacy policy, procedures and Statement of Confidentiality.

______________________________ ______________________________

Signature Date (dd/mm/yyyy)