**CONFIDENTIALITY AGREEMENT FOR EMPLOYEES**

**OF <Name of Medical Practice> (“Medical Practice”)**

I am aware that the Medical Practice has policies and procedures regarding the privacy, confidentiality and security of personal information and that it must comply with British Columbia’s Personal Information Protection Act. I have read the current version of these policies and procedures and understand the requirements.

During my employment with the Medical Practice, I acknowledge that I will be given access to employee and patient information that is deemed sensitive and/or confidential.

I agree that:

1. I shall not share this information with anyone within or outside of the Medical Practice who are not authorized to have this information.
2. I shall not publish such information.
3. I shall not communicate such information without authority.
4. I shall not use or disclose any such information for other than authorized official purposes.
5. I shall not remove any such information from the premises without permission.
6. Should I receive any such information I will accept full responsibility to ensure the confidentiality, accuracy and safekeeping of this information.
7. I shall take every reasonable step to prevent unauthorized parties from examining and/or copying any such information.
8. I shall observe and comply with all policies and procedures of the medical practice with respect to privacy, confidentiality, and security of information during and after my term of employment.

I understand that any breach of the policies and procedures, including misuse or inappropriate disclosure of information, may be grounds for termination of my employment and/or legal action

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| **Employee** | **Name:**  (please print) |  |
|  |  |  |
|  | **Signature:** |  |
|  |  |  |
|  | **Date:**  (dd/mm/yy) |  |

|  |  |  |
| --- | --- | --- |
| **Witness (Privacy Officer)** | **Name:** |  |
|  |  |  |
|  | **Signature:** |  |
|  |  |  |
|  | **Date:**  (dd/mm/yy) |  |