I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree that I will not use or disclose any personal information collected, accessed, or otherwise obtained by me at the <Physician Practice> except for the purposes necessary to carry out my contractual or employment responsibilities. I understand that my duties and responsibilities to maintain the confidentiality of information as described herein shall remain in effect even after leaving the <Physician Practice>.

I understand that I am granted temporary and limited access to patient medical records, proprietary information relating to the <Physician Practice>’s functions, employees and other business records, as required to carry out my employment or contractual responsibilities, and that those records remain under the custody and control of the <Physician Practice>.

I will abide by the <Physician Practice>’s privacy policy concerning personal information and will protect the privacy and security of confidential personal information including:

1. I will only access personal health information as required in order to carry out my contractual or employment responsibilities.
2. I will not collect, use, or disclose personal health information for any purpose other than the purposes for which the information was collected, used or disclosed, or as permitted or required by law.
3. I will protect personal health information from unauthorized access, use or disclosure, including using appropriate security safeguards as identified by the <Physician Practice>, and will adhere to the <Physician Practice>’s policies and procedures.
4. I will strive to keep personal health information that I am responsible for obtaining and entering into the <Physician Practice>’s patient medical records accurate and up-to-date.
5. Subject to any applicable policies or legal requirements with regard to retention of health records, I will securely dispose of personal health information that I create once it is no longer required.

I am aware of and will fully comply with the *Personal Information Protection Act* (PIPA) as directed by <Physician Practice>’s policies. I acknowledge and agree that any breach of this Confidentiality Agreement may result in disciplinary action, including termination of my services to the Physician Practice and in penalties as applicable under PIPA.

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| **Health Authority Employee** | **Name:**  (please print) |  |
|  |  |  |
|  | **Signature:** |  |

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