Lakeridge Health

Statement of Confidentiality

Name: _____ Date: _____
(Please Print in Full, Last Name, First Name)

Affiliation with Lakeridge Health: _____
(Staff, physician, volunteer, student, researcher, resident, consultant, etc.)

I agree that I will observe and comply with Lakeridge Health's confidentiality and privacy policies and procedures.

I understand that I will encounter confidential information in my work with Lakeridge Health. 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.

I understand that when I am accessing any information within or external to the organization in the course of my work, that I am a representative of Lakeridge Health and will at all times represent the organization in a manner consistent with the Mission, Philosophy and Values.

I agree to treat electronic information, hard copy patient records, financial records, personnel information and all other information in accordance with the organization's Privacy Policy.

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.

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

If I have reason to believe that the confidentiality of the password has been violated, I will contact the Information Technology Program immediately for reassignment of a new password.

I understand and agree that the password is and will remain the exclusive property of Lakeridge Health.

I understand and agree that as a safeguard to confidentiality, random audits will be conducted on the use of my computer access to confidential information. I understand and agree that I will be accountable for documented access to any records where I do not have a need to know as outlined in the Systems Audit Policy.

I understand that if I breach this Agreement it will cause deactivation of my system password and could lead to discipline up to and including termination of employment, privileges or affiliation with the hospital as applicable.

I understand and agree that the duty to maintain the confidentiality of the confidential information shall continue after my working relationship with Lakeridge Health is terminated.

Signature: _____ Witness: _____

Witness Name: _____