CONFIDENTIALITY AND DECLARATION OF UNDERSTANDING

☑ Vitalité Zone(s) : ❒ 1B ❒ 4 ❒ 5 ❒ 6 Department (if applicable) : _____

During my association with **the Vitalité Health Network**, I will have access to information and documents of a private and confidential nature.

It is my responsibility to:

1. respect the policies and procedures related to privacy and the protection of personal information including personal health information;

2. treat all administrative, financial, patient/client, employee and other records as confidential information, and to protect them to ensure full confidentiality;

3. respect the privacy and dignity of patients/clients, employees and others;

4. unless there is a legitimate purpose related to my association with my employer, not repeat, disclose or confirm any information revealed by the patient/client/employee, including:
   - the nature of the illness, its cause and treatment,
   - everything divulged to describe the illness,
   - their reactions and their conduct,
   - his/her financial state, domestic life, or any personal information,
   - all the records accumulated during the course of treatment/interaction,
   - and any information leading to their identification.

5. ensure that I do not inappropriately access, use, or disclose confidential information;

6. access only information required for my job purposes;

7. access my own health information only through Health Records or the designated custodian of my information;

8. protect my user name and password;

9. access, process and transmit confidential information using only authorized hardware, software, or other authorized equipment;

10. not release any data / information to a third party unless authorized to do so.

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☑ Vitalité Zone(s) : ❒ 1B ❒ 4 ❒ 5 ❒ 6 Department (if applicable) : _____

I understand:

1. that **the Vitalité health Network** will conduct periodic audits to ensure compliance with this agreement, its confidentiality and privacy policies;

2. that if I am granted electronic inter-zone access to information, the same principles apply to all accesses;

3. to abide by the conditions outlined in this agreement, and that they will remain in force even if I cease to have an association with **the Vitalité Health Network**;

4. that disciplinary action up to and including loss of privileges, termination of employment, termination of a contract, or similar action appropriate to my association with **the Vitalité Health Network** could occur for any breach of privacy or confidentiality that may result from my actions, including disregard for the responsibilities listed above and other reasonable measures that I should be taking in carrying out my daily activities.

By signing, I confirm that I have read and fully understand the above noted document.

Name (print)	Signature	Date

Name of witness (print)	Signature	Date