CENTRAL ZONE
(Halifax, West Hants, Eastern Shore)

PLEDGE OF CONFIDENTIALITY

I pledge to keep confidential any information obtained during the performance of my duties at Capital Health, whether as an employee or an associate[1]. I understand that confidential information includes, but is not limited to, information relating to:

- Patients (such as health records, conversations, registration information, financial history, etc.);
- Capital Health employees and other associates (such as employee records, disciplinary action, etc.);
- Capital Health business information (such as contracts, memos, peer review information, etc.).

I agree that I will read and comply with Capital Health's policies on privacy, confidentiality and security of confidential information. If I require help in retrieving or understanding these policies, I will seek help from my manager or Capital Health's Privacy Office.
I also understand and agree that:

- I will collect, access, use and disclose confidential information on a "need to know basis" only, and only the minimum amount required, as required for my role or as required by law. I will not communicate confidential information either within or outside Capital Health, except to persons authorized to receive such information.
- I will not access the confidential information of family, friends, co-workers or any other individual, unless they are under my direct care or I need to as part of my official duties at Capital Heath.
- I will not access my own personal health information in the custody or control of Capital Health other than through the method approved for the public in the *Release of information from the Health Record* policy.
- I will not share my passwords to electronic information systems with anyone and I am responsible for protecting them. I am responsible for all actions performed when the electronic information system has been opened using my password.
- I will access, process and transmit confidential information using only authorized hardware, software, or other authorized equipment.
- I shall not remove confidential information from Capital Health premises except as authorized. In transit, I shall securely store the information and ensure it is in my custody and control at all times.

[1] Associates means learners/students, physicians, volunteers, Capital Health Board members, contractors, and other authorized representatives or agents.

- I will not alter, destroy, copy or interfere with confidential information, except with authorization and in accordance with Capital Health policies and procedures;
- I shall immediately report all incidents involving loss, theft or unauthorized access to confidential information to my immediate supervisor and to Capital Health's Privacy Office.
- I understand that Capital Health will conduct regular audits to ensure confidential information is protected against unauthorized access, use, disclosure, copying, modification or disposal.

I further understand any breach of my duty to maintain confidentiality may result in corrective action, up to and including significant disciplinary action. Action taken may include, but is not limited to: retraining, loss of access to systems, suspension, reporting my conduct to a professional regulatory body or sponsoring agency, restriction or revocation of privileges, and immediate dismissal.

I understand and agree to abide by the conditions outlined in this agreement, and they will remain in force even if I cease to be employed by or have an association with Capital Health.

Name: _____

Signature: _____

Witness: _____

Date: _____