

CONFIDENTIALITY AGREEMENT FOR EMPLOYEES

I am aware that the medical practice named below has policies and procedures regarding the privacy, confidentiality, and security of personal patient information and that it must comply with Saskatchewan's Health Information Protection Act. I understand that it is my responsibility to be familiar with the requirements outlined in these policies and procedures and I have read the current version of these policies and procedures.

As an employee of the medical practice named below, I agree to observe and comply with all policies and procedures of the medical practice with respect to privacy, confidentiality, and security of patient information. Except when I am legally authorized or compelled to do so, I will not use or disclose personal patient information that comes to my knowledge or possession by reason of my employment with this medical practice.

I understand that any breach of the policies and procedures, including misuse or inappropriate disclosure of patient information, may be just cause for the termination of my employment.

Employee name: (please print)

X _____

Employee Signature

Date (dd/mm/yy)

Medical practice: _____

Witness (privacy officer): (please print)

Dr _____

X _____

Witness Signature

Date (dd/mm/yy)