* This form must be PRINTED, completed BY HAND, and scanned and submitted in PDF format*

HAMILTON HEALTH SCIENCES
CONFIDENTIALITY AGREEMENT
USER TERMS & CONDITIONS

(PRINT CLEARLY)

Name: _____ **Elective Preceptor: _____**
Student ID Number: _____ **Elective Dates: _____**
University: _____
Email address: _____

READ CAREFULLY

I UNDERSTAND that in agreeing to these Terms and Conditions I am entering into a binding legal agreement with Hamilton Health Sciences.

I UNDERSTAND that the username and password(s) that I have received are confidential and for my exclusive use on the Hamilton Health Sciences Information System Applications. I am accountable for all transactions performed using these passwords/codes and agree not to disclose the same to anyone or to attempt to learn another person's password. It is for my exclusive use alone and will not log on and allow another to use applications with my access.

I UNDERSTAND that Hamilton Health Sciences reserves the right to access, monitor, review and disclose information obtained through the hospital's electronic health information systems at any time and that each and every access to the electronic health information in Hamilton Health Sciences systems is electronically captured and logged. Random, as well as targeted audits are conducted on a regular basis. Should a potential breach of the corporate privacy policies be suspected, a formal breach investigation will be initiated and my access rights to any system may be temporarily suspended pending the outcome of the investigation. As Hamilton Health Sciences hosts applications to which patient information from other organizations can be seen; where the PHI relates to these patients from other organizations, I understand that these other organizations may also be asked to undertake an investigation and the results of the activities will be shared.

I UNDERSTAND that all information that I am able to access is CONFIDENTIAL. I agree to access information only for the purpose of providing health care or assisting in the provision of health care to the patient to whom the personal health information relates, or approved education/research activities, or other purposes as required by law and will limit such collection, use or disclosure to that which is necessary for such purposes. I will not at any time during or after my employment/assignment with Hamilton Health Sciences disclose any confidential information to any person or permit any person to examine or make copies of any confidential reports, records or documents. I will ensure any personal health information obtained from these systems is maintained in a secure manner and disposed of according to corporate privacy policy. Should I have any reason to believe that the security of my access/passwords is at risk, I must immediately contact the Hamilton Health Sciences Information Technologies department.

I UNDERSTAND and acknowledge that any unauthorized collection, access, use, disclosure, storage and disposal of confidential personal health information are breaches of personal health information. Failure to abide by the above terms and conditions may result in corrective action, up to and including termination of employed staff, termination of relationship or contract or loss of hospital privileges. In addition I may be responsible for any loss or damage to the Hospital and may be subject to legal or professional disciplinary proceedings.

SIGNATURE_____

DATE: _____