

PLEDGE OF CONFIDENTIALITY

I, _____, (print name) have completed the NSHA Privacy and Confidentiality training module.

I completed the NSHA Privacy and Confidentiality training on: _____
(YYYY/MM/DD)

I pledge to keep confidential any information obtained during the performance of my duties at NSHA, whether as an employee or an associate¹. 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.); NSHA employees and other associates (such as employee records, disciplinary action, etc.); NSHA business information (such as contracts, memos, peer review information, etc.).

I agree that I will read and comply with NSHA'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 NSHA'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 NSHA, 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 NSHA.
- I will not access my own personal health information in the custody or control of NSHA 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.

¹Associates means learners/students, physicians, volunteers, NSHA Board members, contractors, and other authorized representatives or agents.

- I shall not remove confidential information from NSHA premises except as authorized. In transit, I shall securely store the information and ensure it is in my custody and control at all times.
- I will not alter, destroy, copy or interfere with confidential information, except with authorization and in accordance with NSHA policies and procedures;
- I shall immediately report all incidents involving loss, theft or unauthorized access to confidential information to my immediate supervisor and to NSHA's Privacy Office.
- I understand that NSHA 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 after my learning placement at NSHA has ended.

Name of Student/Learner (PLEASE PRINT)

Signature of Student/Learner

Date

Signature of Witness