CONFIDENTIALITY AND INFORMATION SECURITY AGREEMENT

☐ Employee ☐ Student ☐ Physician ☐ Drug Monitor
☐ Independent Contractor ☐ Volunteer ☐ Other (please specify): _____

Location of Work: _____

I understand that in the course of my employment or affiliation with Providence Care I may have access to confidential information, including:

- Personal health information (e.g., patients/clients/residents, Occupational Health records of employees),
- Personnel information (e.g., employment records, photos of staff, persons we care for, volunteers, physicians, etc.), or
- Business information about the organization (e.g., financial and statistical information, internal reports).

In consideration of being provided access to Providence Care's network and confidential information in order to perform my job duties or authorized assignment I understand and agree that:

- I will not collect, use, or disclose confidential information except as authorized to perform my work responsibilities. Under no circumstances shall confidential information be communicated either within or outside of Providence Care, except to other persons who are authorized by Providence Care to receive such confidential information. .
- I will not store confidential information, personal information, personal health information or images on any personal device or device provided to me by Providence Care unless encrypted and authorized by my Manager.
- I will not remove confidential information temporarily or permanently from the premises of Providence Care without specific authorization by Administration.
- I agree my network password is equivalent to my signature and will not be shared with another person. If I have reason to believe my password has been used by someone other than me, I will immediately change my password.
- I will protect the security, availability, and integrity of confidential information by taking and implementing reasonable measures and precautions against risks, such as unauthorized access, collection, use, disclosure, alteration, theft, deterioration, destruction, or disposal of this confidential information.
- I will not post or refer to any confidential information on any social networking sites, unless authorized by Administration.

I will immediately contact the Privacy Officer at 613-544-4900, ext. 53548 or by email at privacyofficer@providencecare.ca if:

- I become aware that personal health information or personal information has been lost, stolen, or accessed, disclosed or used by unauthorized persons.
- If I have reason to believe that my user ID, password, or devices have been interfered with or stolen
- If I become aware of any potential security or privacy incidents.

I understand that:

- At any time Providence Care has the right to audit all files and use of devices supplied by Providence Care. As a safeguard to confidentiality, random and targeted audits could be conducted on the use of my network access to confidential information, and that I will be held accountable for documented access to information not required by me in the performance of my duties.

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- Should a potential breach of confidentiality be suspected, a formal investigation will be initiated and my access rights to confidential information may be temporarily suspended pending the investigation's outcome.
- I have a professional, ethical, and legal obligation to protect the confidentiality of information, and this is a condition of my employment or affiliation with Providence Care.
- My failure to comply with these obligations may result in the termination of my employment or affiliation with Providence Care. It may be required that Providence Care has to report its findings to a regulatory college or Information and Privacy Commissioner of Ontario, or could also be subject to professional disciplinary proceedings under professional misconduct and to legal proceedings.
- I understand and agree that the duty to maintain the confidentiality of the information shall continue after my affiliation or working relationship with Providence Care is terminated.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to carry out my duties and responsibilities in accordance with the above terms and relevant legislation.

Date: YYYY/MM/DD Name (please print): _____ Signature: _____

Date: YYYY/MM/DD Witness Name (please print): _____ Signature: _____