CONFIDENTIALITY AGREEMENT

Name: _____
(Please Print)

Affiliation with SHS: _____
(Example: employee, physician, researcher, student, vendor, volunteer)

1. During my association with Sinai Health System (SHS), I will have access to: (a) SHS corporate confidential or proprietary information relating to the organization's functions, employees and persons affiliated with SHS; and/or (b) personal health information relating to SHS patients, as such term is defined under the *Personal Health Information Protection Act*, 2004 (PHI).
2. At all times, I shall respect the privacy and dignity of patients, employees and all persons affiliated with SHS and I shall only collect, use and disclose personal information (including personal health information) as required by the duties of my position and in accordance with the laws of Ontario and Canada.
3. I shall not inappropriately access, use, copy, modify, remove, or disclose SHS corporate confidential or PHI.
4. This Agreement does not apply to information I previously and independently developed alone or with others prior to my association with SHS that I can substantiate by written records; nor to information in the public domain.
5. I shall maintain the secrecy of all User ID(s) and Password(s) that enable me to access SHS and/or Lunenfeld Tanenbaum Research Institute networks and applications and acknowledge that I am responsible for all access and/or actions carried out under them.
6. I acknowledge that SHS issues policies and procedures that relate to the protection of SHS confidential information and patient information and that compliance with these policies is a requirement of my association with SHS. These policies include, but are *not* limited to:

   - Privacy Policy;
   - Acceptable Use of Information and Information Technology;
   - Privacy Incident Protocol;
   - Other department specific policies and procedures

   I understand that it is my responsibility to familiarize myself with these policies and keep informed of any changes. If I have questions about privacy related policies, including their applicability to me or impact on the performance of my duties, I may contact my supervisor or the Privacy Office.
7. I shall immediately report all privacy breaches involving SHS confidential information and/or patient information to my immediate supervisor and to the SHS Privacy Office.
8. I understand that SHS will conduct periodic audits to ensure compliance with this Agreement and its privacy policies.
9. I also understand that should any of these conditions be breached, I may be subject to corrective action, up to and including termination of employment, loss of privileges, termination of contract, or similar action based on my association with SHS. I understand that a privacy breach is an offence under PHIPA and I may be subject to prosecution by provincial authorities if I am found guilty of this offence.
10. I understand and agree to abide by all of the conditions outlined above. Regardless of changes that may occur to my title, duties, status and/or other terms of my employment or association with SHS, I understand that the terms of this Agreement will continue to apply (including when I no longer have an association with SHS, no matter what the reasons).

Date: _____ Signature: _____ Department: _____

Last Revised: April 2019