Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

PERSONAL HEALTH INFORMATION
PLEDGE OF CONFIDENTIALITY

Concordia Hospital
Deer Lodge Centre
Grace Hospital
Health Sciences Centre Winnipeg
Misericordia Health Centre
Pan Am Clinic
Riverview Health Centre
Seven Oaks General Hospital
Hôpital général St-Boniface General Hospital
Victoria General Hospital

I ACKNOWLEDGE that I have attended the WRHA/health care facility within the WRHA orientation regarding *The Personal Health Information Act* (Manitoba) and have been made aware of the Winnipeg Regional Health Authority ("WRHA") policies on use, collection, disclosure, security, storage and destruction of personal health information. I have also been informed of the contents of the WRHA's Personal Health Information Confidentiality Policy and the consequences of a breach of personal health information.

I UNDERSTAND that unauthorized use or disclosure of such information may result in a disciplinary action up to and including termination of employment/ contract/ association/ appointment, the imposition of fines pursuant to *The Personal Health Information Act*, and a report to my professional regulatory body.

I FURTHER UNDERSTAND that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information whether I acquired the information through my employment/ contract/ association/ appointment with the WRHA or any of the healthcare facilities within the WRHA.

I HEREBY AGREE that as an integral part of the terms and conditions of my employment/ association/ contract/ appointment with the WRHA/health care facility within the WRHA, I will not at any time, during or after my employment/ association/ contract/ appointment, access, use, or disclose any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable legislation and corporate policies governing proper release of information.

DATE: _____ **SIGNATURE:** _____

PRINT NAME: _____

Employee ID# _____
(If Applicable)

PLEASE CHECK ONE:

☐ Employee _____
****SPECIFY DEPARTMENT AND SITE ****

☐ Student _____
(Specify Education Program)

☐ Physician _____
(Specify Discipline)

☐ Volunteer _____
(Specify Site)

☐ Researcher _____
(Specify Research Project)

☐ Other _____
(Specify)

I HEREBY CONFIRM that the above named individual has attended the PHIA Orientation and has been made aware of the Personal Health Information Confidentiality Policy and the consequences of a breach.

DATE: _____

_____
Privacy Officer or PHIA Orientation Trainer