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**Confidentiality Agreement**

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| **NAME:** |
| **POSITION:** |
| **I understand and agree to the following:** |
| □ | I will treat all patient information, whether general or directly related to health care, confidentially and in accordance with the Health Information Privacy Code 2020.  |
| □ | If computer access codes and passwords are intended only for my use in carrying out my duties, I will store them safely and will not give them to anyone else. |
| □ | I will not use the practice’s IT systems, equipment, or the internet for private purposes outside of the service’s usual functions, without the prior approval of the practice manager. |
| □ | I will not disclose information about the day-to-day running of the business, or any issues that arise in my working environment, to anyone at any time, unless that disclosure is necessary for me to perform my duties. This might include information relating to finances, health and safety, human resources, or other operational matters. |
| □ | I understand that my responsibilities under this agreement and the Health Information Privacy Code 2020 continue to apply even if patients are no longer enrolled at the practice, if I no longer work at the practice, or if the practice closes. |
| □ | I understand that failure to observe this agreement is considered serious misconduct which may lead to disciplinary action, including termination of my employment. |
|  | **Signature** ……………………………………………………………………………………... **Date** …………………………Witnessed by ……………………………………………………………………………………………………………………. |