



**OATH OF CONFIDENTIALITY**

I, the undersigned, understand that personal health information maintained by the University or stored on University systems is highly confidential.

I acknowledge that access to, use and disclosure of personal health information is governed by the Health Information Act of Alberta, the University's Information Asset Management Policy, the University's Acceptable Use of Information Assets Policy, and related information management standards.

I further acknowledge that personal health information may only be accessed, used, altered, disclosed, or added to as required to fulfill my employment responsibilities and in accordance with applicable laws and University policies.

I understand that I must immediately notify the Privacy and Records Officer in the Faculty of Medicine if I become aware of a violation of the law or policies referenced above or any unauthorized collection, use, alteration, disclosure, or addition of personal health information.

I understand that failure to abide fully with the foregoing may be grounds for discipline up to and including termination of employment.

**Executed by:**  
Name: (print) \_\_\_\_\_

UC ID: \_\_\_\_\_  
AHS ID \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Received by:**  
Name of Supervisor: (print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_