OATH / AFFIRMATION OF CONFIDENTIALITY
Form # 12 - 800

I, _____, of _____, solemnly
(Print name) (City / Town, Province of residence)

□ Swear / □ Affirm [**check one**] the following:

All clients/patient/residents under the care of Western Health have a right to have their personal information/personal health information treated as confidential.

This statement confirms that I have read and understood policy (2 – 03 – 10) *Confidentiality* for Western Health.

I commit to hold in confidence all personal information / personal health information even after my employment / affiliation with the organization ends.

I understand that I may consult appropriate management personnel regarding this and related policies. I understand that misuse, failure to safeguard, or the disclosure of confidential information without the appropriate approval may be cause for disciplinary action up to and including:

- termination of my employment / contract for service
- reporting to an individual's professional Association / College
- civil action / criminal prosecution.

□ I have reviewed a copy of Western Health's *Confidentiality* policy.

Please note that the completion and signature of this form must be witnessed and stamped by a Commissioner for Oaths appointed in the province of Newfoundland and Labrador.

Printed Full Name: _____

Employee Number: _____

Signature: _____

Date:_____

Commissioner for Oath Stamp