Profile EMR Confidentiality Undertaking

(Please use a pen to complete this form)

I (print name) _____ agree to the following conditions of my access to Profile EMR:

- I will access information within Profile EMR only as necessary to perform my duties as an employee, service provider, contractor or representative of VCH/PHC/PHSA.
- I will not access my own records through Profile EMR and will follow the approved health records process to request access to my records.
- I will not access the records of family, friends or others, unless I am directly involved in the delivery of care or other services to them through my relationship with VCH/PHC/PHSA.
- I will access records consistent with my professional practice obligations.
- I will only use and disclose information obtained through Profile EMR for purposes directly related to the delivery of care or other services to the individual the information is about.
- I will not use or disclose information obtained through Profile EMR for research purposes, unless officially authorized by VCH/PHC/PHSA and in accordance with applicable VCH/PHC/PHSA policies.
- I will not disclose my password to others or allow others to use my Profile EMR account.
- I will comply with all applicable VCH/PHC/PHSA computer information system usage, privacy and other policies and applicable laws, including the BC *Freedom of Information and Protection of Privacy Act* (FIPPA).
- I acknowledge that my use of Profile EMR will be monitored and recorded in an audit log, which is reviewed regularly to ensure compliance with this Undertaking.
- I will comply with this Undertaking in respect of information obtained through Profile EMR whether in electronic or printed form.
- I acknowledge that failure to comply with this Undertaking may lead to disciplinary action, including revocation of access privileges, professional sanctions, suspension or termination of employment or services.

Signature: _____ Date: _____/_____/_____

dd/mm/yyyy

Note: If you are ordering diagnostics (imaging, labs) this signature will print on Profile EMR requisitions. PRINT in BLACK INK.

Phone: _____ E-mail: _____

Please complete as applicable: **Please note that this number will be kept confidential.**

Employee ID # _____ Network Username _____

Physician/NP/RN MSP# _____ Physician/NP College# _____

Return to your Profile EMR Trainer once completed. To be kept on file by Profile EMR Administration.