Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

Confirmation of Confidentiality Undertaking

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required to fulfill the confidentiality requirements of the Act and regulations.

Name (Last name, given name)	**Position:**

Mailing Address

Province Postal code Telephone number

I have implemented security measures sufficient to prevent the unauthorized collection, retention, maintenance, alteration, use or disclosure of Program information, including ensuring that the computer terminal capable of accessing and displaying Program information is inaccessible to anyone other than myself and designated support staff.

I will not access or use any clinical or patient information in PhIP for any purpose other than those authorized by the *Pharmaceutical Information Act* and the regulations.

I agree at all times to treat as confidential information in PhIP and will not participate in or permit the unauthorized release or disclosure of this information.

I agree to adhere to all legislation, policies, procedures and standards issued by PhIP related to the confidentiality, privacy and security of PhIP information.

☐ As Pharmacist-in-charge, I have retained in my office confidentiality undertakings signed by all of the following: • designated support staff • software vendor representative • Pharmacy owner/Chief Signing Officer The computer terminal(s) capable of displaying Program information is/are under the supervision of a pharmacist.	☐ As Participating Prescriber, I have retained in my office confidentiality undertakings signed by all of the following: • designated support staff • software vendor representative The computer terminal(s) capable of displaying Program information is/are under my supervision.
Date	Signature

Please send completed form to:
Pharmaceutical Information Program
PO Box 2000, Charlottetown, PE
C1A 7N8

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