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## CLIENT/GUARDIAN NOTIFICATION & CONSENT POSTER

Insert Logo

<Health Organization> understands the sensitivity of your personal health information. We are committed to protecting your privacy.

Caring for your Information

When you receive health care and services from <Health Organization>, we will collect, use and share your personal health information for these reasons:

* To identify and keep in contact with you about your health care
* To provide ongoing health care
* To support the provision of health care by health care partners
* To help us plan, monitor and improve our care and services to you
* To understand your eligibility for benefits and services
* Where relevant to support billing to medical services
* To analyze, manage and control disease outbreaks and monitor the overall health of people
* As required by law (e.g. court order, reportable conditions)

We do this under, and in accordance with, the *Personal Information Protection Act* (PIPA) and other applicable legislation.

**Understanding Implied Consent**

<Health Organization> operates under an “implied client consent model”. This means by receiving our health care services we have your implied consent for information to be shared as required with those within your “circle of care” for the purpose of your ongoing care and/or treatment (e.g. other health care providers, specialists, lab technologists, etc.).

**Understanding Expressed Consent**

Expressed consent (verbal or written) will be obtained if/when we are collecting, using, and disclosing personal information outside of the “circle of care”, or for secondary purposes outside of those listed to the left (for example, research, teaching/education).

You are entitled to enquire about privacy and to request access to your personal information; to do so please ask to contact our Privacy Officer.

<Health Organization>

ADDRESS

<Insert Address>

PHONE

<Insert Phone>

FOR FURTHER INFORMATION CONTACT OUR PRIVACY OFFICER

**Committed to Empowerment**

**Commitment to Privacy**

**Commitment to Accuracy**

We are committed to ensuring your personal health information is accurate

We are committed to empowering you to understanding your rights regarding the protection of your personal health information.

We are committed to ensuring personal and health information will remain confidential

## PRIVACY CORE VALUES POSTER

Privacy Rights, Commitments, Obligations

As <Health Organization> staff we are committed to core values regarding the privacy of client personal health information.

**Committed to Empowerment**

We are committed to empowering clients to understand their rights regarding the protection of personal health information.

We are committed to ensuring personal health information is accurate

We are committed to ensuring personal and health information will remain confidential

**Commitment to Accuracy**

Insert Logo

**Commitment to Privacy**

<Health Organization> clients have a right to:

* Confidentiality
* Ensuring their personal information is accurate
* Understanding who has access to their personal information and for what purpose
* Understanding how their personal information is retained
* Understanding how and when their personal information is shared
* Ensuring that we recognize and follow relevant legislation regarding protection of personal information

<Health Organization> staff have a commitment to our clients to:

* Ensure our operations and practices embody and recognize the client privacy rights above
* Ensure any aggregation of information or reporting does not identify an individual (either directly or by inference)
* Know and follow our Privacy & Security policies and processes

<Health Organization> recognizes privacy protection can co-exist with the collaborative health care system that enables health and wellness for our people. Our privacy policies and practices formalize our commitment to both client privacy and the need for continuity of care within the “circle of care”.

<Health Organization> recognizes the value of sharing information for the purpose of assessing, planning, and developing First Nations health care programs, and will do so in ways that are consistent and in accordance with our Privacy & Security Framework and policies.

<Health Organization> is committed to supporting staff in understanding and following our Privacy commitments and practices. This will include policy orientation for new staff, and annual privacy training for all staff. Clear roles and responsibilities for privacy protection within the organization will be maintained.

<Health Organization>

PHONE

<Insert Phone>

ADDRESS

<Insert Address>

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## CLIENT/GUARDIAN PRIVACY BREACH POSTER

Insert Logo

We are committed to empowering you to understanding your rights regarding the protection of your personal health information.

Committed to Empowerment

We are committed to ensuring your personal health information is accurate

Commitment to Accuracy

We are committed to ensuring personal and health information will remain confidential

Commitment to Privacy

Privacy Advocate

<Health Organization>’s Privacy Officer is there to support you in any questions, requests, or complaints you may have regarding protecting the privacy for your health information.

**Inquires/Questions/Access**

You have the right to:

* Ensure your personal health information that we hold and protect is accurate
* Understand how your information has been used
* Know the names and organizations to which your personal information has been disclosed

To make any of the above requests, please contact our Privacy Officer who will guide you through submitting a “Client Request for Access to Personal Information”. The Privacy Officer will review our policy with you and assist with fulfilling your request.

**Privacy Breach Notification & Investigations**

<Health Organization> has a policy and process for you to raise any privacy issues you may have and investigate.

You have the right to raise privacy issues, including:

* Any risks or concerns that you see regarding the privacy of your personal health information
* Any privacy complaints you wish to make regarding the handling of your personal health information
* Reporting an actual or suspected breach of your privacy or misuse of your personal information

To raise any of the above privacy issues, please contact our Privacy Officer who will guide you through submitting the appropriate Notification form. The Privacy Officer will review our policy with you and assist in facilitating and reporting back to you the formal investigation of the issues you have raised.

<Health Organization>’s designated Privacy Officer is here to advocate your privacy rights and support you in any questions, requests, complaints that you may have regarding privacy of your health information.

<Health Organization>

ADDRESS

<Insert Address>

PHONE

<Insert Phone>

FOR FURTHER INFORMATION CONTACT OUR PRIVACY OFFICER

## CLIENT/GUARDIAN NOTIFICATION & CONSENT PAMPHLET

ADDRESS

<Insert Address>

FOR FURTHER INFORMATION CONTACT OUR PRIVACY OFFICER

PHONE

<Insert Phone>

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<Health Organization>

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**Commitment to Accuracy**

We are committed to ensuring personal and health information will remain confidential

**Commitment to Privacy**

Caring for your Information

<Health Organization>understands the sensitivity of your personal health information. We arecommitted to protecting your privacy.

**<HEALTH ORGANIZATION>**

## GROUP RELEASE NOTIFICATION & CONSENT POSTER

<enter Event Name>

<enter Date of Event>

By participating and by your presence at the <health organization> hosted event entitled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, you consent to be photographed, filmed and/or otherwise recorded.

<enter LOGO>

Your participation in this health organization hosted event constitutes your consent to such photography, filming and/or recording and to any use, in any and all media throughout the universe in perpetuity, of your appearance, voice and/or name for use on the health organization website or social media pages in connection with the <enter health organization> event entitled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

PHONE

<Insert Phone>

ADDRESS

<Insert Address>

Your appearance, voice and/or name will not be used for any other purpose other than in relation to the event entitled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

You understand that all photography, filming and/or recording will be done in reliance on this consent given by you by entering this area.

If you do not agree to the foregoing, please advise the Health Organization event organizer and Privacy Office that you do not wish for your image, voice or name to be used.

*(Post where event is taking place and is clearly visible to participants)*

**<HEALTH ORGANIZATION>**

## INDIVIDUAL RELEASE NOTIFICATION & CONSENT POSTER

<Event Name>

<Event Date>

I hereby grant <health organization> permission to use my appearance, voice and/or name for use on the health organization website or social media pages in connection with the <health organization> hosted event entitled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand and agree that my appearance, voice and/or name that appears either in video footage and/or still images is in connection only with this named event and could be featured on the health organization’s website and/or social media. I understand that my appearance, voice and name that appears on the health organization’s website or social media will become the property of <health organization> and will not be returned.

PHONE

<Insert Phone>

ADDRESS

<Insert Address>

<enter LOGO>

I acknowledge that since my participation is voluntary, I will receive no financial compensation.

I understand that my appearance, voice and/or name will not be used for any other purpose other than in relation to the event entitled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in connection with the health organization’s website and social media.

I hereby hold harmless and release and forever discharge <health organization> from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am at least 18 years of age and am competent to contract in my own name.

Signed by <print name of individual> with the intent of being legally bound on <enter date>:

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

*(Provide copy to individual and file original in secure location)*

## FAXING GUIDELINES POSTER

√ **Is FAX the best way to send the PHI or is there some other more secure method?**

Insert Logo

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Committed to Empowerment

We are committed to ensuring your personal health information is accurate

Commitment to Accuracy

We are committed to ensuring personal and health information will remain confidential

Commitment to Privacy

**Before you send  
personal information by FAX…**

√ **Did you check the receiver’s FAX number to make sure it’s correct?**

<Health Organization>

√ **Did you complete all the information on the FAX cover sheet?**

√ **Did you verify that you typed the receiver’s FAX number correctly?**

√ **Did you call the receiver to let them know that a FAX has been sent?**

√ **Once sent, have you removed all PHI from the FAX machine area?**

ADDRESS

<Insert Address>

PHONE

<Insert Phone>

FOR FURTHER INFORMATION CONTACT OUR PRIVACY OFFICER