

Policy

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Privacy and Confidentiality Policy

It is the policy of SHCHC to maintain the confidentiality of all information concerning clients, staff and volunteers. Personal information is given to the Centre in trust. It is mandatory that the information remains confidential. It is important that information not circulate outside of the health centre in an unauthorized manner, and it also should not pass between staff for reasons other than appropriate consultations.

SHCHC recognizes the dignity and self-worth of every person and their right to a safe, secure and trusting care environment. The client has the right to considerate and respectful care. The client also has the right to decision making affecting his/her health.

The purpose of this policy is to eliminate inappropriate collection, use and disclosure of client, staff and volunteer information, both inside and outside of the Centre. The purpose is not to prohibit the discussion of client and employee information by professional staff for legitimate reasons.

Ten Principles and Procedures Guiding SHCHC’s Confidentiality Policy:

- Accountability
- Purposes of Information Collection at SHCHC
- Obtaining Consent
- Limiting Collection
- Limiting Use, Disclosure, and Retention
- Accuracy
- Safeguards
- Openness
- Individual Access
- Challenging Compliance

Definitions:

Personal Information:

This policy addresses the uses of personal information of clients, staff and volunteers. Personal information is any factual or subjective information, recorded or not, about an identifiable individual. Examples are age, name, height, weight, medical records, ID numbers, income, ethnic origin, blood type, opinions, evaluations, comments, social status, disciplinary action, employee files, credit records, loan records, or intentions (e.g. to change jobs).

Employee personal information does not include the name, job title, work telephone number or work address, or anything that might appear on a business card.

Section 1. Accountability

SHCHC is responsible for personal information under its control and to maintain its confidentiality at all times. All SHCHC staff share in this responsibility. Our responsibilities in protecting information also entail the assurance that third parties maintain the same levels of privacy as SHCHC.

Staff, volunteers, students, researchers and associates with access to client and employee information are expected to comply with the confidentiality policy. As part of their orientation to the Centre they are asked to sign an Oath of Confidentiality indicating they understand and agree to abide by the ten principles of this policy. A copy of the signed statement will be kept in the personnel records. The obligation of confidentiality remains in effect even after termination of employment.

It is the responsibility of the Director of each component to ensure that any person having access to client and employee information is made aware of the policies and procedures concerning confidentiality and that each individual sign the Oath of Confidentiality.

The Privacy Officer

The role of the Privacy Officer is to provide support to the public and staff around compliance and awareness of confidentiality procedures. The role of this individual is crucial in maintaining confidentiality accountability for clients, staff and volunteers at SHCHC. The Executive Director appoints the designated privacy official. The position receives senior management support and has the authority to intervene on privacy issues relating to any of SHCHC's operations. The name or title of this individual will be made available both internally and externally to ensure their accessibility.

Section 2. Purposes of Information Collection at SHCHC

Information will be gathered from the client/participant or employee and/or third parties for specific purposes. Examples are:

Types of information Collected at SHCHC

- Socio demographics
- Medical history (details)
- ID numbers, card numbers
- Family Members and other contacts
- Living arrangements, educations, doctors
- Legal issues (Children's Aid Society involvement, probation status, Ontario Disability Support Program)
- Criminal reference check (employee)
- Any information needed to provide quality care to our clients.

Reasons for Data Collection

- To provide direct care
- To contact clients/volunteers regarding upcoming events
- To submit information required by funding agencies (e.g. Ministry of Health)
- To plan programs and services
- To employ individuals
- Quality Improvement (e.g. Evaluation and chart audits)
- Any other reason needed to provide services

SHCHC will not collect more information than is needed for an identified purpose.

Section 3. Obtain Consent

The valid and informed consent of the individual is required for the collection, use or disclosure of personal information, except when required by legislation.

Section 4. Limit Collection

SHCHC will limit the amount and type of information gathered to what is necessary for the identified purpose and to guarantee quality services.

Section 5. Limit Use, Disclosure and Retention

SHCHC will use or disclose personal information only for the purpose for which it was collected, unless the individual consents otherwise, or the use or disclosure is authorized by the Act (PHIPA and PIPEDA.)

Staff Access and Disclosure

SHCHC strives to offer a range of programs and services that are holistic and recognize that a multitude of factors can affect a client's health and well-being.

Because we strive to serve clients holistically by offering them access to a variety of programs to best meet their needs, it is important that there are open lines of communication between service providers and Centre programs to ensure the most effective and efficient utilization of services possible. There are both formal and informal means of sharing information ranging from verbal consultation to referral forms and shared care.

Clients will be made aware that some disclosure between providers needs to occur in order to maintain/provide an appropriate level of consultation and/or supervision or for purposes of continuity of care when providers change.

Sometimes a client may wish to specify that certain staff members or third parties not have access to the file or to part of the information therein (Information Lock-Box). However, the client must be aware of the possibility that their request may limit the service provided.

Referrals

When the provider refers a client to an outside professional, certain client information may be required by that professional in order to assess the client. The consent is implied if the client agrees to the referral. Written consent is mandatory if the third party is not a health care professional.

Retention and Disposal

All client records should be retained according to the records retention schedule of the Centre. The information contained in the records belongs to the client, but the physical record belongs to the Centre.

Purpose of Retention:

- to facilitate provision of service at future time
- to provide historical data for future identification or verification of facts
- to provide material for statistical collection and research

Section 6. Be Accurate

It is the responsibility of the Centre staff to:

- Create and maintain client records which are clear, concise, comprehensive, professional, and which serve to further the care of the client.
- Minimize the possibility of using incorrect information when making a decision about the individual or when disclosing information to third parties.

Amendments

Amendments to the records shall be made only when there has been an error in recording (not an error in decision).

Section 7. Use Appropriate Safeguards

Security safeguards appropriate to the sensitivity of the information are intended to protect personal information. Personal information will be protected against loss or theft (regardless of the format in which it

is held). Appropriate security safeguards will be used to provide necessary protection including physical measures (restricting access to offices etc), technological tools (passwords etc), organizational controls (confidentiality agreements etc). Employees access the computers, files and other recorded information of the SHCHC and its programs only as authorized and required for the effective delivery of programs

The record and any other documented information confidential to the client or staff member is the property of SHCHC, whose responsibility it is to take all reasonable precautions to secure the information against loss, fire, theft, defacement, tampering, access or copying by unauthorized persons.

Section 8. Be Open

SHCHC has readily available to staff, Board of Directors, volunteers, students, associates and clients specific information about our policies and practices relating to the management of personal information.

SHCHC will ensure the policies and practices are understandable and easily accessible. The following will also be available for all staff and clients:

- name or title of the person who is accountable for SHCHC's privacy policies and practices
- name or title of person to whom access requests should be sent
- how an individual can gain access to his or her personal information
- how to comment, complain or inquire about privacy issues
- brochures or other information that explain your SHCHC's policies, standards or codes for confidentiality.

Section 9. Give Individuals Access

Upon request, a client shall be informed of the existence, use and disclosure of his or her personal information and shall be given access to that information.

An individual shall be able to challenge the accuracy and completeness of the information and have requests for corrections added to their file. A client may request that his/her practitioner make a correction on his/her health care record. This correction will be added to the file, the original will not be altered. If a correction is requested and is not made, the client may make a statement of disagreement, on the "Review of Personal Record" form, which is kept in the client's file and the client may further their complaint to the Privacy Officer or other relevant officials.

Client's Right of Access:

1. A client is generally entitled to have access to his or her own records kept at the Centre. Clients may read the file, obtain a photocopy of their file, or receive the information verbally or by a summary letter from their practitioner. If a client requests his/her records for a legal purpose, the practitioner consults with the client and SHCHC lawyer as necessary. The client must sign a Consent to Release Information form before the records are forwarded to the client's representative.
2. Any client no matter what his/her age is entitled to confidentiality regarding his/her health care. However, release of information about competent clients under the age of 16 years must be judged on a case-by-case basis.
3. A parent or guardian of a child who is 16 years or older shall not be permitted access to any information or records concerning the client without the written permission of the client. (Refer to competence to consent section.)
4. Within 30 days the SHCHC will: either make available the record requested; or, inform the individual in writing of the reasons for refusal to provide the record, and of his or her right to appeal the refusal to the Ontario Privacy Commissioner.

The normal 30-day response time limit can be extended for a maximum of 30 additional days, according to specific criteria as follows:

- If responding to the request within the original 30 days would unreasonably interfere with activities of SHCHC
- If additional time is needed to conduct consultations
- If additional time is necessary to convert personal information to an alternate format
- If SHCHC extends the time, the employee must notify the individual making the request within 30 days of receiving the request, and of his or her right to complain to the Privacy Commissioner

Exceptions:

SHCHC may refuse an individual access to all or part of a personal information record if such access could reasonably be expected to: result in harm to the individual or to another person; unjustifiably invade the privacy of or reveal the identity of another person; or, be in violation of other legislation.

Section 10. Challenging Compliance

Any individual (staff, client etc) is able to launch a challenge concerning compliance with the above principles to the Privacy Officer

SHCHC will:

- Have available simple and easily accessible complaint procedures (see Client Feedback Policy).
- Inform complainants of avenues of recourse.
- Investigate all complaints received.
- Investigate and remedy any breach of information with the client's best interest in mind.
- Take appropriate measures to correct information handling practices and procedures.
- Record the date a complaint is received and the nature of the complaint.

The Privacy Officer will review all complaints, and make changes to the policy as needed, and ensure complaint response meets legislative rights and timeliness. The Officer will notify the Privacy Commissioner as necessary.

Confidentiality Procedure

1. Accountability

Confidentiality of Staff and Centre Information

Employee, Volunteer and Student Information

Each employee, volunteer and student shall maintain confidentiality concerning employees, volunteers and students at the Centre, specifically with regard to personnel files or employment records.

Business Affairs

An employee or volunteer shall not disclose the business affairs of the Centre and shall not use for his/her purposes or the purposes of any other organization or individual any information that s/he may acquire about the operations of the Centre, as per the conflict of interest policy.

Section 2. Purposes of Information Collection at SHCHC

Staff members must identify the reasons for collecting personal information before or at the time of collection explaining why it is needed and how it will be used

The purposes for collecting data will be defined as clearly and narrowly as possible to ensure the individual can understand how the information will be used or disclosed.

Any new purpose for information will be identified and the individual's consent will be obtained before using it.

Clients or employees must be informed, either orally or in writing, of all purposes of information collection.

All obtained consents will be recorded for easy reference in the client's or employee's file in case an individual requests an account of such information

Section 3. Obtain Consent

The client or employee must be informed in a meaningful way of the purpose for the collection, use or disclosure of personal information. Consent is only valid if the individuals understand how their information will be used.

The individual's consent will be obtained before or at the time of collection, as well as when a new use is identified

Information disclosure will not be made a condition for supplying service, unless the information requested is required to provide the specific service.

The implications of withdrawing their consent will be explained to the client or employee.

For an individual who does not have the capacity to consent, consent will be obtained by an appropriate substitute decision maker (refer to appendix).

Valid and Informed Consent

Informed Consent means that the client or employee or substitute decision maker has received information that *a reasonable person in the same circumstances* would require in order to decide about the benefits and risks of providing their information and the alternative courses of action and the consequences of not providing their information.

Written consent is always preferable to verbal consent. The written consent form must be approved by the Privacy Officer. However, if written consent is unobtainable in a given circumstance, a note should be made in the client's file with the time and date that the verbal consent was received and the purpose of the disclosure. The requirements for valid consent are equally applicable to verbal and written consent.

Requirement for Valid Consent

A valid consent must meet the following criteria:

Consent must be voluntary

The client must have the physical and mental capacity to consent.

The client must have been properly informed.

To ensure informed consent the following criteria should be met:

The service provider must disclose to the client the nature of the information gathering, its purpose, any risks, and the consequences of not providing consent. The practitioner must answer any specific questions posed by the client as to the risks, side effects or any other foreseeable consequences involved in the information gathering. The client must always be given the opportunity to ask questions or to rescind their consent.

The practitioner must note in the client records when consent explanations have been made, as this can confirm that a client was properly informed.

Where there is a language barrier, interpretation will be provided by either a family member or an interpreter provided by SHCHC. Client should have the opportunity to choose between using a member of the family or an interpreter.

Competence to Consent

An incapable person cannot provide valid consent. If a practitioner determines a client is unable to consent the proper substitute decision-maker must then make the decisions. All rights of an individual apply to a person who has been authorized to act on behalf of an individual.

People who are judged to be incompetent in one instance are not necessarily incompetent in all instances, and may be capable of consenting in a later situation.

People have the right to make unreasonable decisions, so long as they are competent and can demonstrate that they fully appreciate the consequences of their decisions.

When a patient's mental capacity is in doubt:

- The lead service provider makes a judgment as to whether the client is able to appreciate the nature and consequences of their consent;
- The lead service provider, if unable to render an opinion, consults a second service provider, preferably a psychiatrist;
- The lead service provider notes in the client's file that competency testing and consultation were undertaken, and the conclusion reached.
- The proper substitute decision-maker must make the decisions when an incapable person cannot provide valid consent (See Appendix A).
- Findings of incapacity come with obligations according to the law with respect to providing information to their clients (See Appendix B).

Where Consent Is Not Required (Exceptions)

Please note: In instances of violence (indicating potential harm to staff, volunteers or other clients) or banned client issues please refer to the SHCHC Violence and Banned Client Policies for further detail and procedure. As per clauses described below, these circumstances negate the regular consent requirements and procedures. However, minimal information disclosure to thwart the risk is expected.

Potential Liability to the Centre

Upon the authority of the Executive Director, client records should be provided to the Centre's own lawyer, own liability insurer or an adjuster or a lawyer acting on behalf of the Centre's insurer.

Subpoenas, search warrants, court orders

If served with a subpoena, search warrant or other form of court order, every attempt should be made to comply strictly with its terms. The Executive Director and/or Program Director will be immediately notified so that legal advice may be sought where appropriate.

Child abuse

Where there are reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse, the suspicion and the information on which it is based shall be reported promptly to the Children's Aid Society.

College investigations and Coroners

Records must be made available upon request to investigators appointed by the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Royal College of Dental Surgeons of Ontario, the Coroner and/or any other regulatory/professional body as appropriate. Such investigators should first furnish evidence of their appointment. The Executive Director and/or program director should be notified immediately of these requests.

Prevention of Imminent Harm

Where a care provider believes that client information must be disclosed so as to prevent serious and imminent harm to either a client (e.g. Client is threatening suicide), or to a third party (e.g. Client is threatening to harm someone else), the minimum amount of information judged necessary to thwart the potential harm is disclosed. While such matters must be dealt with on a case-by-case basis, the staff member involved will inform their manager and/or Executive Director of their decision and the action taken.

Worker's Compensation Board

Reports in respect of an injured worker must be furnished upon the written request of the Worker's Compensation Board.

Communicable Diseases

A provider who forms the opinion that a person is infected with a communicable disease must report to the Medical Officer of Health in accordance with the Health Promotion and Protection Act and Regulations.

In Emergency

Where the client is unable to consent, a practitioner has the duty to do what is immediately necessary without consent. In exceptional circumstances to protect life, health or safety, communication of essential information with others may be required without the consent of the specific client.

To a government institution that has requested the information, identified its lawful authority, and indicates that disclosure is for the purpose of enforcing, carrying out an investigation, or gathering intelligence relating to any federal, provincial or foreign law; or suspects that the information relates to national security or the conduct of international affairs; or is for the purpose of administering any federal or provincial law

To an investigative body named in the Regulations of the Act or government institution on the organization's initiative when the organization believes the information concerns a breach of an agreement, or a contravention of a federal, provincial, or foreign law, or suspects the information relates to national security or the conduct of international affairs. If made by an investigative body for the purposes related to the investigation of a breach of an agreement or a contravention of a federal or provincial law.

If required by law. Release of Information to a Police Force - No employee shall be permitted to release health information to any police force without a search warrant or the written consent of the client.

For statistical, scholarly study or research (must be approved under SHCHC's research policy).

Records of Mandatory Disclosures

The Centre will keep a record of all search warrants and subpoenas executed against them. Staff will advise the Executive Director or designate, before complying with such demands. Staff will make every effort to supply a copy of requested documentation and retain the original. If not possible, a copy must always be made before the original can be released. All copies must have the date of the copy and be clearly labelled "copy".

Section 4. Limit Collection

Staff members will:

- Limit the amount and type of information gathered to what is necessary for the identified purpose
- Ensure that they can explain why the information is needed
- Ensure that there is a justifiable purpose for obtaining and recording information about a client.
- When clients, who are victims of abuse, for example, request their counsellor not record information for fear of subpoenas, providers must act in the best interest of the client. They must keep their notes honest and in the best interest of continuity of care. Providers must always be aware of the minimal requirements of legal and professional standards of recording information.

Section 5. Limit Use, Disclosure and Retention

Staff members will:

- Use or disclose personal information only for the purpose for which it was collected, unless the individual consents otherwise, or the use or disclosure is authorized by law.
- Keep personal information only as long as necessary to satisfy the purposes.
- Keep personal information used to make a decision about a person for a reasonable time period. This should allow the person to obtain the information after the decision and pursue redress.
- Document any new purpose for the use of personal information and obtain necessary consents.
- While communicating with other providers it is important to keep in mind that the goal of any communication should be to ensure that we are providing the best service possible. It is also important for clients to fully understand the type of communication that may occur between providers so they can make an informed decision regarding the use of SHCHC services.

Access to Client and employee information

Authorized staff

Personally identifiable information should be restricted to:

- staff providing service to the client, and their supervisor
- staff assigned to tabulate and collate data
- appropriate administrative personnel
- volunteers and students who need access to parts of client records to complete their work or research.

Case discussions, consultation, examination and treatment are confidential. When staff, client or volunteer safety is at risk (reference the Violence and Banned Client Policies and Procedures) this will take precedence. However, in any instance, the minimum amount of information judged necessary to thwart the potential harm is disclosed.

For problem solving purposes or for finding an appropriate resource for a client, staff does not need to identify clients in any way.

If staff members have mutual clients, clients can be identified in discussions. Staff consultations are essential for updating providers on new and pertinent information about a client, seeking consultation and supervision in serving a client or developing plans of care for a client.

Sometimes a client may wish to specify that certain staff or third parties not have access to the file or to part of the information therein (Information Lock-box). These staff or third parties will be listed on the comments section of the Client Caution Sheet. They may have to be notified that there is information that is not available to them; it is up to the referring staff to decide to inform the staff or third-party provider of the presence of an Information Lock-box. This will be done with the best interest of the client in mind. Staff

or third parties will not have access to any part of the chart that may contain the locked information. However, the client must be aware of the negative impact on service including the potential that their request may mean that we cannot provide them service. The above paragraph also pertains to employee information.

Day to Day Maintenance in the Limitation of Disclosure

- All records are returned to the designated area at the end of the day.
- Appointment and records books are kept closed when not in use.
- Cases and clients are not discussed in open areas, such as waiting areas, the kitchen, lunchroom or hallways.
- All telephone conversations are kept as private as possible
- Client data is never left on computer screens where it could be viewed by a passer-by, nor is it left on the counter of the communication centre
- Clients may not wish to be acknowledged off-site. Staff, with the exception of outreach workers, should wait until the client initiates contact.
- Providers may keep informal notes about their clients (telephone messages, etc.) that are only needed temporarily. While these notes may not necessarily become part of a client's file they should be treated with the same level of confidentiality and with the same confidentiality practices. When discarding informal notes care should be taken to ensure that they are destroyed in an appropriate manner.

Referrals

When a practitioner refers a client to a professional outside SHCHC for care, certain client information is required by that professional in order to assess the client. The consent is implied if the client agrees to the referral. Written consent is mandatory if the third party is not a health care professional, if you are sharing information that was not agreed upon during the initial referral or if you are sending a complete chart. When in doubt, fill out a written consent form.

Requests for Information

Requests for information from third parties should be in writing. The letter is placed in the client or employee file. It should be noted what information was disclosed, when and by whom.

Except where required by law, client and employee information is never released without signed and dated consent, or that of the client's substitute decision maker.

When a service provider outside SHCHC requests data, the original, signed "Release of Information" form from that outside service is accepted as authorization or the client may sign a SHCHC "Release of Information" form.

Guidelines for Releasing Client and employee information to Third Parties

Records are the property of the Centre. The originals are not to be released.

There must be a written consent form for the release of client information, signed by the client or an authorized person if the person is incompetent. In addition, the content of the written consent shall specify the third party or parties to whom the information is to be released. Before records are copied, each page is numbered. Information should not be released over the telephone without verbal consent or being in possession of a Consent or Release of Information and without being certain of the identity of the person making the telephone request. Originals of the written request should be placed in the client records. A notation shall be made in the records stating: What information or records were disclosed and by whom the records or information were disclosed.

Retention and Disposal

All client records should be retained according to the records retention schedule of the Centre.

Purpose of Retention:

- to facilitate provision of service at future time
- to provide historical data for future identification or verification of facts
- to provide material for statistical collection and research

Retention Time

Medical records should be retained for a period of ten years after the client attains the age of 18, or for the clients over 18 for ten years after the date of the last entry in the record. Records that might be required for the continuing care of the client, to defend a legal action, as a requirement of a government health insurance plan or by any other licensing authority should be kept longer as required.

Records are considered "inactive" five years after the last entry. Following the initial five-year period, the records will be securely stored in the basement for an additional five years.

Computer records are still maintained for clients who have stopped visiting the Centre. For such clients, the computer records are marked "inactive".

Employee records are maintained for seven years after the last entry.

Disposal of Records:

A regular destruction schedule for client and employers records will be established in accordance with the record retention schedule of the Centre.

There will be an annual review to identify those client records to be destroyed in accordance with the records retention schedule of the Centre.. Records should be destroyed by a shredding process. A register will be established and maintained which identifies all client records that have been destroyed. This register will indicate file number, client name and date record destroyed.

Section 6. Be Accurate

It is the responsibility of the Centre staff to:

- Create and maintain client records which are clear, concise, comprehensive, professional, and which serve to further the care of the client.
- Minimize the possibility of using incorrect information when making a decision about the individual or when disclosing information to third parties.

Amendments

Amendments shall be made only when there has been an error in recording (not an error in decision). They should be crossed out with a single line (but still legible), initialled and dated. An arrow should point to the corrected entry. The correction should be made in the margin. The correction shall be dated and initialled.

Section 7. Use Appropriate Safeguards**Telephone, fax or e-mail Client Information Disclosures**

Information is only disclosed following proper consent practices.

Information is never given to anyone if there is any question as to the person's identity.

Storage of Information**Security measures:**

Secure access shall be assured in all areas where client and employee information records are kept including case files, records stored in computer banks, central file areas and any sub-systems created for convenience.

Locked cabinets, locked shelves or a locked room in which records information is housed will assure security.

Client files will not be removed from the Centre unless the component manager or equivalent provides special authorization.

The photocopying of client records should be the responsibility of authorized staff.

All copies of information sent outside the Centre must be endorsed with the date the material was sent and contain the label "copy".

Section 8. Be Open

Clients are told at their first visit, and as required, about the policy of sharing information within the Centre and with professionals to whom they may be referred. They are invited to ask their practitioner further questions. They are asked to sign a General Consent form.

It is stressed that information is only shared as necessary to give optimum health care. Clients are assured that no information from their records will be released to anyone except as above without their consent. Clients are also informed at their first visit that they have access to their personal information records.

Clients are also made aware of the limits of the confidentiality policy and mandatory disclosure.

Section 9. Give Individuals Access

Upon request, a client shall be informed of the existence, use and disclosure of his or her personal information and shall be given access to that information.

Please note: As a person's client status is personal information, the Centre is unable to disclose or confirm a person's status as a client of the Centre without that client's consent. For example, we are unable to pass along a message from a friend or relative (without the client's prior approval) as agreement to do so would confirm their client status.

An individual shall be able to challenge the accuracy and completeness of the information and have requests for corrections added to their file.

- The practitioner should note any disagreement on the file and advise third parties where appropriate.
- Provide any help the individual needs to prepare a request for access to personal information.
- Notify the individual of the approximate (monetary) costs before processing the request.
- Inform the individual in writing when refusing to give access, setting out the reasons and any recourse available.
- Affix the client's rebuttal next to the disputed information. The original information will not be altered.

Client's Right of Access:

Obtaining Access

1. The records are the property of the Centre. The originals shall not be released. If the client wishes to read the original records a staff member must be present to ensure that the records are not altered or removed.
2. To access their client and employee information, the client should make a written request by signing the Release of Information Form.
3. The original of the written request is placed with the client's record and a copy is given to the client.
4. A notation is made in the records stating:
 - what information or records were disclosed

- when the information or records were disclosed
 - by whom the information or records were disclosed
5. If the client would like a copy of any portion of their file, they must complete a Waiver for the Release of Medical Documents form. Before records are copied, each page is numbered. If printing the copy from an electronic source, watermark the pages with 'copy' when printing (see appendix C).

Because records may be difficult to read and interpret and may indeed mislead or alarm a client, he/she shall be encouraged to review the records with a provider so that the information can be explained.

Section 10. Challenging Compliance

Breach

The Component Director, together with the Executive Director, represents the responsible authority. Any breach of confidentiality may result in disciplinary actions. Every effort will be made to determine if the breach of confidentiality qualifies as intentional or unintentional and whether or not the breach is material to the Centre's clients (or employees, if the breach pertains to employee information). The course of action of the Executive Director will be based upon this information, surrounding factors, the client's (or employee's as applicable) best interests and, if appropriate, advice from the Information Privacy Commissioner. The breach may need to be reported to the Board of Directors and to the Centre's clients (or employees) whose information has been compromised. Please refer to the Incident of Risk Policy. The Privacy Officer will keep a record of the breach, the follow up actions and any corrective measures that were implemented.