PERSONAL HEALTH INFORMATION ACT (PHIA) INFORMATION SHEET

The WRHA, as a Trustee, is bound by Manitoba’s Personal Health Information Act (PHIA). It is the law. This Act obliges us to protect our patients’ confidentiality and privacy.

While you are associated with the WRHA, we require that you adhere to the following:

1. Keep all patient personal health information confidential and private. Do not discuss any patient information you may hear or see with anyone who does not need to know this information to do their job.

2. Do not share any patient personal health information:
   - in the presence of someone who does NOT need to know this information
   - in public places

3. If you are not sure what is the right thing to do in a specific situation, discuss it with (Program Medical Director) or designate or call the Privacy Officer at 787-1245.

4. The Confidentiality Policy and PHIA-related policies are available in the HSC Corporate Policy Manual from the (Program Medical Director) or designate and on the WRHA web site at www.wrha.mb.ca.

IMPORTANT FACTS ABOUT PHIA ARE:

1. PHIA is about “Personal Health Information” (PHI) which includes all information that could identify an individual and includes:
   - health or health history
   - behavior from illness or treatment
   - type of care or treatment provided
   - numbers or symbols, i.e., PHIN
   - financial situation, home conditions or difficulties
   - other private matters such as age, sexual orientation

2. Patients have the right to confidentiality about their PHI.

P.T.O.
3. Information that could identify someone and link it to their PHI is not to be shared with the exception of the following:
   
   • the person needs the information to do their job
   • the patient gives permission to disclose the information

4. Everyone associated with the WRHA is governed by PHIA, including you.

6. I understand that I am required to keep all “personal health information” confidential.

Dated this _____ day of ______________, 2___________

___________________________  ____________________________
Witness’ Name (print)        Provider’s Name (print)

___________________________  ____________________________
Witness’ Signature           Provider’s Signature