**Confidentiality Statement for PEG Participant**

***Practice Name*** and WellSouth Primary Health Network work collaboratively to provide comprehensive and equitable health care services for all patients.

As a participant in the PEG for ***Practice Name***, you will be trusted with information about our healthcare system and the patients we serve. This may include information about patient care experiences, diagnoses, quality and safety, and other sensitive information.

Non-Disclosure of Confidential Information (including patient information) means when you are carrying out your role as a PEG participant you must comply with provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994. It is important for you to know that health information can only be used and disclosed as permitted by law. This means that health information cannot be shared outside the health care facility, and it cannot be shared in any written, verbal, or email communications with friends or family unless specifically permitted by law.

The easiest way to remember what this law means is the saying, “What you hear or see here must remain here i.e in the room.” We require your cooperation in following these rules. Any inappropriate or unauthorised use of patient related information or disclosure to third parties will result in termination of your services and may give rise to a complaint to the Office of the Privacy Commissioner. You may not speak to the media about any aspect of your role or comment or post any information about your role on any social media, unless you are specifically asked to consult with your community networks by the project working group.

Confidential ***Practice Name*** business and operational information must not be disclosed to third parties who are not lawfully entitled to receive it. Any documentation, software or other intellectual property created by you in the course of carrying out your role for ***Practice Name*** is the property of ***Practice name*** and/or WellSouth and must not be published or used without the consent of both parties.

Please sign below to let us know that you have reviewed this information, understand it, and agree to it. Signing your name means that you have read and understood the information above, that you have had a chance to ask questions, and that you agree not to share any health information or other confidential information outside the practice in any written, verbal, or email communications.

I, PEG participant’s name and surname accept the terms and conditions outlined above in this letter.

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Verifying person Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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