[PRACTICE HEADED PAPER]

LOCUM CONFIDENTIALITY AGREEMENT

**Name of Locum:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Council Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that **Confidential Information** means all confidential information (including patient information, personal data, know-how, ideas and concepts, financial information and operational processes) and such other proprietary information relating to this Practice (however recorded or preserved), which is disclosed or made available to me whether before or after the date of this agreement (in any form or medium), directly or indirectly.

I acknowledge that this Practice has custody and control of Confidential Information, which it must protect for ethical, legal and proprietary reasons.

In consideration of this Practice retaining my services as a Locum Doctor during which time certain Confidential Information may be made available to me, I agree to be bound by the following principles of confidentiality:

1. Any Confidential Information which I have accessed or become aware of by virtue of my engagement with this Practice will be kept confidential both during and after my engagement.
2. I shall only discuss cases seen during my engagement with this Practice with other clinical staff of this Practice as may be strictly necessary and appropriate.
3. I shall not disclose or remove any Confidential Information from this Practice without the prior written consent of a Practice Partner.
4. [I shall not access medical records belonging to me, members of my family or those known to me without the prior written consent of a Practice Partner.]

**Locum Doctor:**

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

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Practice Manager / Practice Partner:**

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

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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