**HIPAA WORKFORCE MEMBER AGREEMENT**

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| --- | --- | --- |
| PI Name |   | IRB Number       |
| Study Title       |
| Date |       |

This Agreement is entered into as of the date specified below, by \_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Researcher”) in favor of the Johns Hopkins HIPAA affiliated covered entity group acting through its Johns Hopkins Privacy Office.

REPRESENTATIONS

1. Researcher is employed by the Johns Hopkins University.

2. Researcher is working on an IRB approved human subjects research project (the “Protocol”) under the direction of \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Designated JHM Co-Investigator”) who is a credentialed Johns Hopkins Health System workforce member.

3. Researcher understands that this Agreement applies only to Researcher’s activities preparatory to research in identifying, and possibly contacting, potential study subjects related to the Protocol (the “Research Services”) in accordance with JHSPH HIPAA policy. When providing those Research Services, Employee will be deemed to be a member of the workforce of the Johns Hopkins HIPAA covered entities.

AGREEMENTS

1. To qualify as a member of the workforce of Johns Hopkins HIPAA covered entities, Researcher agrees as follows:

a. To take Johns Hopkins HIPAA training as required of all other Johns Hopkins HIPAA covered entities’ workforce members.

b. To be bound to the standard Johns Hopkins Confidentiality Agreement for Workforce Members in the form attached hereto.

c. To comply with the Johns Hopkins Medicine and JHSPH HIPAA policies.[[1]](#footnote-2)

d. To retain all data (PHI and otherwise) accessed as part of the Research Services only on servers located within the firewalls of the Johns Hopkins HIPAA covered entities and/or on the physical premises of the Johns Hopkins HIPAA covered entities.

2. Researcher shall not make any use or disclosure of the PHI or other data and information under this Agreement other than for the Research Services.

3. This Agreement shall continue until such time as Researcher no longer is providing the Research Services, unless earlier terminated by the Johns Hopkins Privacy Office.

WITNESS the signature of the Researcher as of the \_\_     \_\_\_\_ day of      \_\_\_\_\_\_\_\_\_, 20\_     \_\_

\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Researcher Signature of Designated JHM Co-Investigator

CONFIDENTIALITY AGREEMENT FOR

WORKFORCE MEMBERS--GENERAL

I understand that I require information to perform my duties at the Johns Hopkins University or Johns Hopkins Health System entity by which I am employed or for which I am volunteering (“Johns Hopkins”). This information may include, but is not limited to, information on patients, employees, plan members, students, other workforce members, donors, research, and financial and business operations (collectively referred to as “Confidential Information”). Some of this information is made confidential by law (such as “protected health information” or “PHI” under the federal Health Insurance Portability and Accountability Act) or by Johns Hopkins policies. Confidential Information may be in any form, e.g., written, electronic, oral, overheard or observed. I also understand that access to all Confidential Information is granted on a need-to-know basis. A need-to-know is defined as information access that is required in order to perform my work or volunteer duties. If my duties change, my need-to-know also may change.

I agree to the following:

* I will review the applicable Notice of Privacy Practices and the Johns Hopkins policies on confidentiality and privacy, including any policies that are specific to the entity and department in which I conduct my activities. I understand that these will be made available to me by my manager.

* I will access, use and disclose Confidential Information in keeping with the abovementioned policies and only on a need-to-know basis.
* I will contact my supervisor or manager (if applicable) in order to obtain proper permission before I make any other use or disclosure of Confidential Information. If I have no manager or I am the manager, I will seek advice from the Health System or University Legal Counsel or the Johns Hopkins Privacy Officer to assure that the use or disclosure is within the law and Johns Hopkins policies.
* I will not disclose Confidential Information to other patients, other plan members, friends, relatives, co-workers or anyone else except as permitted by Johns Hopkins policies and applicable law and as required to perform my work or volunteer duties.
* I will not post or discuss Confidential Information, including pictures and/or videos on my personal social media sites (e.g. Facebook, Twitter, etc.). Likewise, I will not post or discuss Confidential Information on Johns Hopkins-sponsored social media sites without the appropriate approval in accordance with established Johns Hopkins policies and procedures.
* I will not access, maintain or transmit Confidential Information on any unencrypted portable electronic devices (e.g. Blackberries, Androids, iPhones, iPads, etc.) and agree to use such devices, with respect to Confidential Information, in accordance with Johns Hopkins policies only.
* I will protect the confidentiality of all Confidential Information, including PHI, while at Johns Hopkins and after I leave Johns Hopkins.

All Confidential Information remains the property of Johns Hopkins and may not be removed or kept by me when I leave Johns Hopkins except as permitted by Johns Hopkins policies or specific agreements or arrangements applicable to my situation.

If I violate this agreement: if I am an employee, I may be subject to disciplinary action, up to and including discharge, under applicable human resources policies; if I am a volunteer, I may be subject to termination of my right to volunteer, under applicable program policies. In addition, under applicable law, I may be subject to criminal or civil penalties.

I have read and understand the above and agree to be bound by it. I understand that signing this agreement and complying with its terms is a requirement for me to work or volunteer at Johns Hopkins.

**Use of Confidential Information at Johns Hopkins**

It is important that the entire Johns Hopkins Health System and Johns Hopkins University community share a culture of respect for Confidential Information. To that end, if you observe access to or sharing of Confidential Information that is or appears to be unauthorized or inappropriate, please try to make sure that this use or disclosure does not continue. This might include advising the person involved that they may want to check the appropriateness of the use or disclosure with the Johns Hopkins Privacy Office or the Health System or University Legal Counsel. It may also involve letting your manager (if applicable) or others in authority at the Health System or the University know about the issue or possible issue. Use of the Compliance Hotline (telephone #: 1-844-SPEAK2US (1-844-773-2528)) allows this to be done anonymously, if need be.

1. NOTE: JH HIPAA policies, forms, minimum HIPAA training requirements, etc. are available on the JH Privacy Office intranet site at <http://intranet.insidehopkinsmedicine.org/privacy_office/>. [↑](#footnote-ref-2)