

SJHC CONFIDENTIALITY AGREEMENT

Investigator:

I, the undersigned, agree to adhere to the **SJHC Policy on Information Security and Confidentiality (SE 10-1-1) and Policy on Release and Confidentiality (SJ 04-04-01)** and understand that a breach of either or both of these policies will be just cause for termination of my employment and/or affiliation with the hospital. I agree that all health information, which I may have access to, is to be dealt with in keeping with the policies and procedures of St. Joseph's Health Centre with respect to confidentiality. If identifying information is collected, the information will be kept secure and identifiers removed at the completion of collection. I also accept full responsibility for protection of information that has been collected by a delegate on my behalf.

Print Name of Investigator

Signature of Investigator

Date

(Note: if there are additional investigators, please print, sign and date names in the blank space below attesting to the above confidentiality agreement)

Additional Investigators (if applicable):

**SJHC Research Ethics Board
CHART REVIEW APPLICATION FORM**

Please address the following ethical concerns regarding access to confidential medical information. The response to these issues should be sufficiently detailed and complete to allow the REB to determine the merit of the investigation and that sufficient protection is in place to guard the confidentiality and security of patient information.

1. Primary objective for the study (include the study rationale):

2. Specific hypothesis or research question to be addressed:

3. Specify the data to be collected or attach data collection form:

4 Please identify all sources of data:

Inpatient _____ Day Surgery _____ Emergency _____

Other _____

5. Proposed number of research subjects/charts:

6. Target time period of charts required for review:

7. Do you require health records to produce a list/report? YES NO

8. How will relevant patient charts be identified?

9. Will any identifying information be recorded from the charts? YES NO

If YES, please respond to the following:

i) Please list the subject identifiers to be used on data collection forms (ie. names, initials, DOB, OHIP, Hospital ID number) and justify their inclusion.

ii) Will individual identifiers be removed once the relevant data is collected?
 YES NO

If no, please justify.

iii) Is there any anticipated linkage of the data to be collected with other data? If so, how will the linked information be treated?

10. Are photocopies of chart contents requested? YES NO

If YES, how will photocopies be disposed of?

11. Security & Confidentiality:

i. Please indicate how data will be stored:

- Computerized files
- Hard copy
- Other (Please specify):

ii. Where will hard copy data be stored (ex. filing cabinets, specify department name, room number, address, etc.)? Who will have access to this area?

N/A

iii. If storing study data in computerized files please specify where the database is located and who has access.

N/A

Is the computer password-protected?

iv. Will data be transferred electronically?

YES NO

If YES, by what medium? (e.g. e-mail, diskette or CD, memory stick)

v. Describe any security measures in place to protect confidentiality.

vi. What will happen to the data at the end of the study (ex. anonymized, destroyed)?

vii. Who will have access to data in the future?

viii. How will confidentiality be maintained during long term storage of study records?

N/A

12. Will these data be available or distributed to others? If so, specify how confidentiality will be protected.