CONFIDENTIALITY AGREEMENT FOR MEDICAL STAFF, RESIDENT STAFF AND OTHER CREDENTIALED PRACTITIONERS

I understand that I will require various types of information to perform my duties for Johns Hopkins Medicine (which may include Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Community Physicians or other affiliated organizations) (hereinafter "Johns Hopkins"). This information may include, but is not limited to, information on patients, employees, students, other workforce members, donors, research, and financial and business operations. 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 professional duties.

I agree to review the Johns Hopkins policies on confidentiality and privacy, including the Notice of Privacy Practices, and the Medical Staff bylaws applicable to the entity or entities providing privileges. The policies applicable to me will be provided to me by Johns Hopkins. I will access, use and disclose confidential information in keeping with these policies and only on a need-to-know basis. Before I make any other use or disclosure of confidential information, I will contact my department or division head in order to obtain proper permission. If I am the department or division head, 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 protect the confidentiality of all confidential information, including PHI, while at Johns Hopkins. I will not remove any confidential information from Johns Hopkins except as permitted by Johns Hopkins policies or specific agreements or arrangements applicable to my situation.

If I knowingly violate this agreement, I will be subject to disciplinary action under the Medical Staff Bylaws and, if I am employed by a Johns Hopkins entity, under applicable Johns Hopkins 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 and attend patients at Johns Hopkins.

Name: _____ Daytime Phone: _____

Signature: _____ Date: _____

Social Security Number: _____

Johns Hopkins Dept/School: _____

Use of Confidential Information at Johns Hopkins

It is important that the entire Johns Hopkins Medicine 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 Officer or the Health System or University Legal Counsel. It may also involve letting your department or division head (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 #: 1-877-932-6675) allows this to be done anonymously, if need be.