INSTITUTIONAL REVIEW BOARD

DATA USE/CONFIDENTIALITY AGREEMENT

Name: _____

School/Sponsor:_____

Name of Research Protocol: _____

Principal Investigator: _____

East Tennessee Children's Hospital Institutional Review Board values and protects the confidentiality of hospital information including patient information and other information contained within the computerized information system and medical records/office charts.

Your signature on this form signifies your understanding and acceptance of the following responsibilities. Please read carefully before signing.

1. I will use hospital information in my custody only for the performance of the research described in the protocol application.
2. I will not alter or in any way change hospital information.
3. I will not divulge hospital or third-party information to anyone, regardless of his or her relationship with the organization, who does not have privilege to the information.
4. I will not attempt to gain access to information to which I am not specifically authorized.
5. I will not publicly release confidential information.

I HAVE READ & AGREE TO THE ABOVE CONDITIONS _____/_____
Signature Date