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**CONFIDENTIALITY AGREEMENT: PATIENT INFORMATION**

I hereby acknowledge that, as an investigator and representative of an investigator at the Dubai Health Authority (DHA) I may gain access to DHA patient information for the approved research protocol, which is required to be kept confidential. I agree that:

1. I will keep confidential all patient information to which I gain access.
2. I will access and use patient information only in connection with a research protocol that has received Dubai Scientific Research Ethics Committee (DSREC) approval and will not access information of other patients of DHA. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records
3. I will assure the data collected in connection with the approved research protocol will not be copied/ duplicated/published for any other purpose.
4. I will not disseminate patient information except to the extent required by law.
5. I will not discuss patient information in public places or outside of work.
6. I will take all necessary precautions to ensure that the access and handling of patient information are conducted in ways that protect patient confidentiality to the greatest degree possible. This includes maintaining such information in a locked file cabinet as well as in the password protected secured systems. In addition making sure that the access to research patient information is restricted only to the research team.
7. I understand that any and all references pertaining to rare conditions and/or sensitive issues (HIV/AIDS, STD, sexual assault or child abuse etc.), are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.
9. My obligation to safeguard patient confidentiality continues after my termination of employment with the Institution.
10. I will not disclose in any report or publication resulting from any research study and information that identifies or can be associated with the identity of an individual patient, including, but not limited to, patient name, address, record number, or attending physician’s name.
11. I will not attempt to contact any individual patient or any relatives of the patient without prior approval from the higher authority at the study site, except that I may contact any patient, from whom I am attending physician.
12. I understand and agree that the archival and/or destruction of the research data is a responsibility of a Principal Investigator and it will be done as per data archival or destruction policy in the institution.

I understand that improper disclosure or misuse of patient information, whether intentional or due to neglect on my part, is a breach of patient confidentiality, which can result in the loss of access to clinical information for myself and my employer and may result in disciplinary action by my employer.

I also understand that improper access, disclosure or misuse of patient information may result in legal action being taken against me with the consent of the concerned patient.

**I agree to the terms and conditions mentioned above.**

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| **Name** | **Signature** | **Date** |
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