## HIPAA Drive Access Form | Research HIPAA Data

This form is required to create, modify or terminate access to the ETSU HIPAA Compliant Storage Drive. Please complete this form and fax or email it to the HIPAA Compliance Office: 423.439.8510 or hipaa@etsu.edu. **This** form must be completed and signed by the Principal Investigator.

In some cases, training may be required before access is granted. Access terminates for all users at the end of each calendar year. Notice will be provided to the folder administrator of record thirty (30) days prior to termination. The folder administrator must submit a new request form prior to the end date to avoid disruption of service. It is the responsibility of the folder administrator to ensure the access to protected health information ("PHI") of each user is appropriate based on the user's position on study staff. The folder administrator must immediately submit this form for termination or modification of access where a user no longer requires such access to perform their research duties as assigned.

Once your request for a new folder is processed, you will be able to create subfolders yourself. Please note, subfolders inherit the access rights of the main folder. If you need a separate folder with different access rights, you must submit a separate request form for one to be created. or ☐ Create New Main Folder ☐ Modify Access Rights Only.\* \*If simply modifying access rights, complete only Section 1 and Section 2 and obtain the required signatures. ETSU IRB Protocol No.: Study – Site Location: Section 1: Folder administrator- Principal Investigator Name: [last] [first] [middle] Title/Position: Telephone No.: Department / Clinic: ETSU Email Address: Building / Floor Location: The Folder administrator will have read and edit access. Check One: ☐ Add User ☐ Modify User Access ☐ Delete User

## Section 2: Please list all study staff for the above protocol, who require access to the associated data.

Name:						
	[last]	[first]	[middle]			
ETSU Email Address:						
Building / Floor Location: _						
This user requires (Check	One): □ Read	d-Only Access	□Read and Edit Access			
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						
Name:						
	[last]	[first]	[middle]			
Title/Position:						
Telephone No.:						
Department / Clinic:						
ETSU Email Address:						
Building / Floor Location: _						
This user requires (Check	One): ☐ Read	d-Only Access	□Read and Edit Access			
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						
Name:						
	[last]	[first]	[middle]			
Title/Position:						
Telephone No.:						
Department / Clinic:						
ETSU Email Address:						
Building / Floor Location:						
This user requires (Check One): ☐ Read-Only Access ☐ Read and Edit Access						
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						

Space is provided at the end of this form for additional users.

## Section 3: Description of PHI to be stored on the HIPAA Compliant Storage Drive, including the types of identifiers present. Mark all that apply.

□ Patient Names □ All elements (except years) of dates related to a patient (including birthdate, admission date, discharge date, date of death, and exact age if over 89) □ Patient Telephone numbers □ Patient Fax numbers □ Patient Email addresses □ Patient Social Security Numbers □ Patient Medical record numbers □ Patient Finger or voice prints □ Patient Device identifiers and serial numbers	□ Patient Addresses (all geographic subdivisions smaller than state, including street address, city county, and zip code) □ Patient Health plan beneficiary numbers □ Patient Account numbers □ Patient Certificate or license numbers □ Patient Any vehicle or other device serial numbers □ Patient Web URLs □ Patient Internet Protocol (IP) Addresses □ Patient Photographic images □ Any other unique identifying number, characteristic or code that might identify a Patient					
Please provide a brief description of the PHI that will be maintained on the HIPAA Drive.						
Please provide a brief explanation as to why this PHI canr system.	not be maintained inside the electronic medical record					
[signature of Folder administrator]	[date]					
[signature of Department Chair or Dean]	[date]					
If you need additional information or have questions, pleas	e contact the HIPAA Compliance Office at 423.439.8533.					
This section for use by HIPAA Compliance Office.						
Date Received: ☐ HIPAA training Folder Name Assigned:	y verified Date Forwarded to ITS:					
Date Folder Administrator Notified of Access:  Notes:						

## Additional users who require access to this folder to perform their job duties as assigned.

Name:						
[last]	[first]	[middle]				
Title/Position:						
Telephone No.:						
Department / Clinic:						
ETSU Email Address:						
Building / Floor Location:			-			
This user requires (Check One):	☐ Read-Only Access	□Read and Edit Access				
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						
			_			
Name:[last]	[first]	[middle]				
Title/Desition:						
-			-			
This user requires (Check One):	·		_			
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						
Name:						
[last]	[first]	[middle]				
Title/Position:						
Telephone No.:						
Department / Clinic:						
Building / Floor Location:			_			
This user requires (Check One):	☐ Read-Only Access	□Read and Edit Access				
Check One: ☐ Add User ☐ Modify User Access ☐ Delete User						