**APPLICATION for RESEARCH on DECEDENTS’ INFORMATION (HIPAA)**

**For Research within the Covered Entity (Biomedical Research)**

## University of Utah, Institutional Review Board

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| Principal Investigator: |  | | | | Contact Person  (if different from PI): |  | | |
| Employee/Student#: |  | | Phone: |  | Employee/Student#: |  | Phone: |  |
| Email: |  | | | | Email: |  | | |
| Department: |  | | | | Department: |  | | |
| Campus Address*:* |  | | | | Campus Address: |  | | |
| Co-Investigator(s)  (Name & affiliation or “None”): | |  | | | | | | |
| Names of persons to have access: | |  | | | | | | |
| Title of Study: | |  | | | | | | |

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| 1. Topic of research preparation: |
| 1. Description of information to be reviewed: |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Data elements requested: | | | | | | | |
|  | DX  DRG | | Acct #  MR# | Admit Date  Disch Date | Pt Name  Pt Addr | | Procedure  Proc. Date |
| Other patient identifiers  (please specify): | | | | | | |
| 1. Specific diagnoses or procedures requested for search: (must be completed) | | | | | | | |
| 1. Time period of records: From       to      . | | | | | | | |
| 1. Location of records to be reviewed: | |  | | | | | |
| 1. Will any identifiable information be “Disclosed” outside the “Covered Entity”?  Yes;  No. If so, please complete and attach Information for Accounting of Disclosures. | | | | | | | |
| 1. INVESTIGATOR'S REPRESENTATION   As the principal investigator for this research, I certify the following:   * + - 1. I seek to review Protected Health Information[[1]](#footnote-1) solely for research on the PHI of decedents;       2. The PHI for which I seek use or access is the minimum necessary for the research purposes.       3. If I am researching heritable diseases, I will obtain and keep in my files documentation of the death of such individuals (e.g., death certificate or autopsy report). | | | | | | | |
| 1. Principal Investigator’s signature: | | | | | | Date: | |
| 1. Principal Investigator’s position:       If PI is a student, volunteer faculty member or staff, a faculty sponsor’s signature is required. | | | | | | | |
| * If required: Faculty sponsor’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Faculty sponsor’s name: | | | | | | Date: | |
|  | | | | | |  | |
| Authorized IRB Reviewer | | | | | | Date | |

1. *Protected Health Information (PHI)* is information about the past, present, or future physical or mental health of an individual that identifies or could be use to identify the individual and is created or received by a Covered Entity. (45 CFR 160.301, 164.501; information about the provision of health care and payment for health care is included; some educational and employment records are excluded.) [↑](#footnote-ref-1)