**REQUEST FOR IRB APPROVAL OF WAIVER OF AUTHORIZATION TO USE PROTECTED HEALTH INFORMATION**

Principal Investigator: Click here to enter text.

Title of Project: Click here to enter text.

PI Email and Phone: Click here to enter text.

1. I am requesting this waiver of authorization for the following purpose: (please select only one):

|  |  |
| --- | --- |
|  | The collection of initial screening data to recruit potential research subjects, or to determine study eligibility only. Authorization is required for the remainder of the research study) |
|  | Retrospective reviews, research database or repository, or other research study where obtaining a signed authorization is not practical. |

2. The following protected health information will be created, collected, used and/or disclosed for the purpose of conducting this research:

Click here to enter text.

3. I certify that the use or disclosure of protected health information involves no more than minimal risk to the privacy of individuals based on at least the following elements:

a. An adequate plan is in place to protect the identifiers from improper use and disclosure. The plan is as follows (select all that apply):

|  |  |
| --- | --- |
|  | All electronic study data will be password protected |
|  | Passwords will be changed on a regular basis |
|  | Access to study data will be restricted to the following authorized personnel only: |
|  | All paper study records will be kept in locked file cabinets and access limited to authorized study personnel only. |
|  | Other: Click here to enter text. |

b. An adequate plan is in place to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law.

The plan is as follows: Click here to enter text.

c. The protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by HIPAA regulations.

4. I certify that the research could not be practicably conducted without this requested waiver.

5. I certify that this research could not practicably be conducted without access to and use of the protected health information.

6. I certify that I will only access the minimum amount of PHI necessary to accomplish

I attest that the above statements are correct and complete to the best of my knowledge.

**SIGNATURE OF PRINCIPAL INVESTIGATOR**:

|  |  |  |
| --- | --- | --- |
| Click here to enter text. |  | Click here to enter a date. |
| Principal Investigator Signature  (Acceptable signatures: Electronic submission  from PIs mailbox or electronic signature) |  | Date |

IRB Use Only

This waiver was approved under:

Full Review\_\_\_Expedited Review\_\_\_

Signature of IRB Chair or Designee:

Approval Date: