Request for Waiver of HIPAA Authorization

Principal Investigator:

Study Title:

PI Address:

PI Telephone / Email:

Date of Submission:

The Phoebe Putney Memorial Hospital Institutional Review Board (Federalwide Assurance Number 000005458) may waive or alter the requirement to obtain authorization from research subjects in order to use or disclose their protected health information, provided that the investigator justifies, and the IRB agrees, that specific criteria have been met.

Explain how your research meets the criteria by answering the following:

In this study, how does the use or disclosure of protected health information involve no more than minimal risk to privacy of the subjects?

What is your plan to protect identifiable health information from improper use and disclosure?

What is your plan to destroy the identifiers? Include how and when.

Why is it not practical to obtain authorization from subjects?

Can the research be done without the protected health information?

☐ Yes

☐ No

If no, explain:

Please complete the following to describe selection criteria for records required (e.g.; all cancer patients seen in the cancer clinic), the dates of the records required (e.g.; clinic visits from July 1, 2005 through December 31, 2010), and data fields required for the research.

Selection Criteria for records required

Dates of required records

Data fields required (list fields required from an electronic data base, or list fields to be recorded from the paper record by the researcher)

Anticipated sources of information (check all that apply)

☐ Paper medical records

☐ Electronic files

☐ Other:

Principal Investigator Acknowledgement
I declare that the requested information constitutes the minimum necessary data to accomplish the goals of the research. ***I agree that the protected health information will not be re-used or disclosed to any other person or entity, except as required by law, for the authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by the Privacy Regulation (45 CFR 164.512).***
P.I.'s Name: _____ Date: _____
Electronic Signature:

Faculty Advisor Acknowledgement
I declare that the requested information constitutes the minimum necessary data to accomplish the goals of the research. ***I agree that the protected health information will not be re-used or disclosed to any other person or entity, except as required by law, for the authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by the Privacy Regulation (45 CFR 164.512).***
Faculty Advisor's Name: _____ Date: _____
Electronic Signature:

Submit Form

Please save a copy of the form for your records and submit the final form electronically by clicking the "Submit Form" to the left or at top of page.

IRB Review of Request for Waiver of HIPAA Authorization
(Completed by IRB Office Only)

On the date noted below, as prescribed by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 [HIPAA], PPMH IRB approved an alteration or waiver of authorization for the use and disclosure of protected health information in the above entitled study. The PPMH IRB determined that the alteration or waiver, in whole or part, of authorization satisfies the above criteria as indicated. This application was reviewed and approved under full convened board procedures at 45CFR 46.108(b) or expedited review procedures at 45 CFR 46.110.

☐ **Full Board Review** **Date:**

Approved By:

☐ **Expedited Review** **Date:**

Approved By: