



Request for Waiver of Patient Authorization To Use/Disclose Health Information in Research

Research Protocol: _____

Principal Investigator: _____

Advisor: _____

Please furnish the requested information to support the request for waiver.

Waiver of Patient Authorization to Use Patient Health Information (PHI) in Research

By signing this request for waiver, I certify to each of the following:

1. The use/disclosure of PHI involves no more than minimal risk to the privacy of individuals
 - i. There is a plan to protect the identifiers from improper use and disclosure—briefly describe: _____
 - ii. There is a plan 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—briefly describe: _____
 - iii. The PHI 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 PHI would be permitted.
2. The research cannot practicably be conducted without the waiver or alteration—briefly describe: _____
3. The research cannot practicably be conducted without access to and use of the PHI—briefly describe: _____

Principal Investigator Signature

Date