I hereby request to review individually identifiable health records for the following research purpose (researcher must indicate one of the four purposes below):

☐ 1. Research project approved by an IRB, with individual subjects’ written authorization granted. Please attach all documents below.
   __Copy of IRB approval attached.
   __Copy of each subject’s authorization attached OR Copy of informed consent signed prior to April 14, 2003.

☐ 2. Research project approved/exempted by an IRB, with individual subjects’ written authorization waived by IRB or Privacy Board. Please attach all documents below.
   __Copy of IRB approval/exemption determination attached.
   __Copy of Waiver of Authorization by IRB/Privacy Board signed by Chair or designated Member attached OR Copy of Waiver of informed consent approved by HIC/IRB prior to April 14, 2003.

☐ 3. Research project requiring only decedent information. Note no representation required if individual(s) deceased for more than 50 years. I represent that (researcher must check all):
   □ The use or disclosure I am requesting is solely for research on the protected health information of decedents.
   □ I understand that I will be required to provide documentation of the death of such individuals, if requested.
   □ The protected health information I am seeking is necessary for research.
   Description of research: ____________________________________________________________

☐ 4. Protected health information is required for activities preparatory to research. I represent that (researcher must check all):
   □ Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research.
   □ The protected health information for which use or access is sought is necessary to prepare research protocol or other activity preparatory to research.
   □ No protected health information will be removed from the YNHHS facility in the course of my review.
   Description of proposed research: __________________________________________________

I agree that the information I have requested will only be used for the research purpose stated in this Request Form and its accompanying documentation. I agree that I will use only the information necessary for the research purpose described. I will protect the confidentiality and security of this information while it is in my possession, and will destroy identifiers if required by accompanying documentation.

____________________________________  ______________________________________
Signature of Investigator                Date of Request

____________________________________  __________________________  __________
Print Name                              Facility and Department    Phone Number

Must check one of the boxes below:

☐ YSM or YSN Full-Time Faculty Member    ☐ YNHHS Attending Physician
☐ Neither of the above (Please complete box on page 2 if request is for the purpose of research on decedents (#3) or for research preparation (#4) if requesting YNHHS facility medical records).
Type of health information to which access is requested (medical records, imaging studies, pathology information, lab information, etc.) and proposed review site:

- Electronic records: data base(s) to be interrogated:
- Paper records: site of review (facility and department):
- Imaging studies: site of review (facility and department):
- Other:

Please describe your request below if Medical Records/Health Information Management (HIM) or Information Systems (IS) Department needs to generate the list for you. Otherwise, please attach the list of records you are requesting.

For research on decedents or for review preparatory to research:

If investigator is not a YSM/YSN Full-Time Faculty Member or YNHHS Attending Physician, the signature of one of the following is required: YNHHS Clinical Department Chair or Section Chief; YSM/YSN Full-Time Faculty Member; YNHHS Attending Physician; YNHHS Nurse Manager; YNHHS Hospital Department Head.

Signature of Attesting Individual

Facility and Department

Position

Print Name

Phone Number

Date

For individuals added to the research purpose indicated above:

If individual(s) will be involved in a research study or research purpose listed above, but are not listed on the protocol, a signed memo from the principal investigator must be attached identifying these individuals and representing that all necessary training has been completed, and the individual(s) must sign below:

I agree to the terms and conditions set forth above regarding access to PHI for the research purpose indicated above.

Signature of Additional Researcher

Print Name

Date

Signature of Additional Researcher

Print Name

Date

Reserved for data manager.

Data manager:

Date form submitted:

Date PHI access provided:

Reason PHI access not provided:

Accounting required: ☐ Yes ☐ No