Yale New Haven Health System/Yale University
Yale-New Haven Hospital
Request for Access to Protected Health Information for a Research Purpose

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