University of South Alabama

REQUEST FOR WAIVER OR ALTERATION OF SUBJECT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Project Title:
Investigator(s):
Department:
Phone #: _____ Email address:

Check the activity for which the waiver or alteration of subject authorization is being requested:

Use of PHI for the conduct of the study itself
Use of PHI to identify potential subjects for recruitment
Use of PHI to contact potential subjects regarding study participation

2. If an alteration of authorization is being requested, briefly describe the proposed alteration of the authorization and attach a copy of the altered authorization section of the consent form. If a waiver is being requested proceed to number 3.

3. The following protected health information will be created, collected, used or disclosed as a result of the subject's participation in this research: (Please select all that apply)

Names
Postal address
Dates *All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;*
Telephone numbers
Fax numbers
Electronic mail address
Social security numbers
Medical record numbers
Account numbers
Health plan beneficiary number
Certification/license numbers
Vehicle identifiers and serial numbers, including license plate numbers
Device identifiers and serial numbers
Name of relative
Web Universal Resource Locator (URL)
Internet Protocol (IP) address number
Biometric identifiers, including fingers and voice prints
Full face photographic images and any comparable images
Any other unique identifying number, characteristic, or code

4. There is minimal risk to the privacy of the subject because:

a. State how the PHI will be protected from improper use and disclosure. (i.e., the information will not be disclosed unless it is stripped of all identifiers, Data will be coded prior to any disclosure with P.I. retaining a master list with a code access)

b. Identifiers will be destroyed upon completion of :
Data collection
Data analysis
Specimen processing
Other :

- OR -

c. Identifiers will be retained indefinitely because:
This is a longitudinal study
Of federal requirements
Other:

5. The research cannot practicably be conducted without access to the PHI because:
PHI is needed to identify subject eligibility
Explain:
PHI is needed to answer the research question
Explain:
Other:

6. List all entities (i.e., USA), organizations and/or persons involved in the use and disclosure of the PHI.
(Note: If the identifiable health information is shared outside of USA, additional documentation may be necessary to account for the disclosure(s). Furthermore, the sharing of PHI outside of USA may require the outside party to comply with HIPAA requirements.)

The information listed in the waiver application is accurate and all research staff will comply with the HIPAA regulations and the waiver criteria. I assure that the information I obtain as part of this research will not be reused or disclosed to any person or entity other than those listed on this form, except as required by law.

Principal Investigator Date

For IRB Use Only

This waiver was approved under: Full Review Expedited review

Signature of IRB Chair or Designee Approval Date