Use this form to request a waiver to access an individual's Protected Health Information(PHI). The completed form must be reviewed and approved before any access to PHI.

Study Title:	
Principal Investigator:	
IRBNet #:	

Choose the option that applies:

☐ Pre-Screening of health care records to identify possible subjects for recruitment purposes.

Complete sections "General Information" and "Partial Waiver of Authorization"

☐ Review of records to obtain information that currently exists or will be collected in the future for a research study without a subject's written consent and authorization.

Complete sections "General Information" and "Waiver of Authorization"

General Information

1. **Describe the health information that will be obtained or used in this research, i.e. diagnosis, medications, lab results, imaging, etc. (Specific identifiers will be checked below):**

2. **Indicate the source of the health information (check all that apply):**

☐ **AdventHealth or AdventHealth Medical Group medical records**
☐ **Other, indicate source of PHI:**

3. Select all of the identifiers that will be used in this research

☐ Names	☐ Vehicle Identification/License Plate numbers
☐ Addresses including ZIP	☐ Account numbers
☐ All date (except year) and ages over 89	☐ Biometric identifiers
☐ Telephone numbers	☐ Device identifiers
☐ Fax numbers	☐ Full face photos & any comparable images
☐ Social Security Numbers	☐ URLS
☐ Medical Record Numbers	☐ IP Addresses
☐ Health plan numbers	☐ Email addresses
☐ Certificate/License numbers	☐ Any other unique identifying number, characteristic, or code (except those assigned by an investigator to code the data)

Partial Waiver of Authorization

1. **The use or disclosure of Protected Health Information (PHI) involves no more than minimal risk to the privacy of individuals. Describe how the use of PHI in this research poses no greater than minimal risk to participants' privacy.**

2. **Describe the plan to protect identifiers and indicate where PHI will be stored and who will have access (list all entities that might have access to the PHI such as IRB, sponsors, FDA, data safety monitoring boards, and anyothers given authority by law).**

3. **Describe the plan to destroy the participant identifiers at the earliest opportunity consistent with the recruitment procedures, unless retention is required for reasons of health, research, or law. Please explain if the participant identifiers will be stored or retained and the length of time they will be stored or retained:**

4. **Recruitment for this research could not practicably be conducted without a partial waiver of authorization because:**

5. **Recruitment for this research could not practicably be conducted without access to and use of the PHI because:**

Waiver of Authorization

1. **The use or disclosure of Protected Health Information (PHI) involves no more than minimal risk to the privacy of individuals. Describe how the use of PHI in this research poses no greater than minimal risk to participants' privacy.**

2. **Describe the plan the protect identifiers and indicate where PHI will be stored and who will have access (list all entities that might have access to the PHI such as IRB, sponsors, FDA, data safety monitoring boards, and anyothers given authority by law).**

3. Describe the plan to destroy the participant identifiers at the earliest opportunity consistent with the conduct of research, unless retention is required for reasons of health, research, or law. Please explain if the participant identifiers will be stored or retained and the length of time they will be stored or retained:

4. The research could not practicably be conducted without the waiver because:

5. The research could not practicably be conducted without access to and use of the PHI because:

PI Assurances

In applying for a waiver of authorization or partial waiver of authorization, I agree to the following:

A) The identifiers used for this research study will not be used for any other purpose or disclosed to any other person or entity (aside from members of the research team identified in the research application), except as required by law.

B) If at any time I want to reuse this information for other purposes or disclose the information to other individuals, I will seek approval from the IRB.

C) I will comply with AdventHealth HIPAA policies and procedures and with the use and disclosure restrictions describes above.

I assume responsibility for all uses and disclosures of the PHI by members of the study team.

Date:

Principal Investigator Signature: