FORM: Waiver of HIPAA Authorization Request			
Document No.:	**Edition No.:**	**Effective Date:**	**Page:**
HRP-220	**004**	**19 Jun 2020**	**Page 1 of 1**

Complete this form if the research study justifies waiver of the requirement to obtain an individual's authorization as set forth by HIPAA regulations.

IRBNet #: **Principal Investigator:**

Title:

1. Explain why the use or disclosure of Protected Health Information (PHI) involves no more than a minimal risk to the privacy of individuals:

2. Describe the plan to protect identifiers and indicate where PHI will be stored and who will have access:

3. Please describe the procedure used to destroy all the PHI collected during the study (electronically, paper, audio/video, photography, other), OR please describe why the identifiers collected during the study will not be destroyed:

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 PHI because:

6. Explain why PHI obtained for this study is/are the minimum PHI needed to meet the research objectives.

Principal Investigator Certification: The information listed in this Waiver of HIPAA Authorization Request is accurate. My research staff will comply with the HIPAA regulations and waiver criteria. I assure that the PHI obtained as part of this research will not be reused or disclosed to any other person or entity other than those listed on this form, except as required by law. If at any time I want to reuse this PHI for other purposes or disclose the PHI to other individuals or entities, I will first seek approval of the AdventHealth IRB Orlando.

Principal Investigator's Signature (required): _____

Date: _____