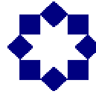

University Health System
Authorization for Pre-Research and Decedents

TO: RESEARCH DEPARTMENT RESEARCH COORDINATOR (MS #96) PHONE NUMBER: 8-0086		DATE:
REQUESTOR:	TITLE:	DEPARTMENT:
PHONE NUMBER:	PAGER NUMBER:	FAX NUMBER:

RESEARCH TOPIC DESCRIPTION:

PURPOSE OF RECORD REVIEW: Pre-Research ☐ Decedent ☐

GENERAL DESCRIPTION OF INFORMATION SOUGHT: (Please attach Data Extraction Form)

ESTIMATED DATE REQUIRED FOR COMPLETION OF REVIEW:	RECORDS TO BE REVIEWED IN THE MEDICAL RECORDS DEPARTMENT AT:
Individuals besides myself that will be accessing information: (Credentials by Medical Dental Staff required—**Residents must have faculty approval)	UNIVERSITY HOSPITAL ______ UNIVERSITY HEALTH CENTER DOWNTOWN ______
	CONTACT TELEPHONE NUMBER:

Protected health information used by or disclosed to me as a researcher is necessary to prepare a research protocol or for similar purposes preparatory to research or for research on decedents. I agree that:

(1) **the use or disclosure is sought solely for such purposes**
(2) **no protected health information will be removed from the University Health System premises by the researcher in the course of the review, and**
(3) **the protected health information for which use or access is sought is necessary for the research purposes**

Upon completion of the records review, a list of all patients accessed to complete this prepatory or decedent's research will be filed with the UHS Research Department.

Printed Name Investigator:	Signature and Date Investigator
**Printed Faculty Name	Signature of Faculty (if Required)

UHS Approval:

BCHD# 210 NS 1/03