**REQUEST FOR RESEARCH DATA**

**Please check:**

**□Medical Records/Health Information Management □Pathology/Laboratory Information Services □Information Services □Other (Specify)**

**Reason for request:** **Date:**

Have you applied for an IRB review of your access to Protected Health Information?  Yes  No

If ‘Yes’, provide the IRB #       and approval date

If ‘No’, then this research retrieval request will be considered "Preparatory to Research" and you must attest to the following:

I,      , understand and agree that the use or disclosure of protected health information (PHI) is sought solely to develop a research concept or idea and not for any other purpose. I will not remove or further disclose any PHI from UTMB in the course of the review and I will only use and access PHI necessary for the purpose of determining if a research project is feasible. I will not make contact with any of the patients whose records I have reviewed, and I will not publish any data obtained pursuant to this access. I understand that if I wish to use or disclose any PHI obtained during this review for any other purpose, I must obtain IRB approval.

Status of Requestor:

Faculty  Staff  Student  Other: (Specify)

Department:

Email:       Phone:

**Please give a detailed description of the information requested. The descriptions should include items like diagnoses, procedures, ICD-9-CM codes, or lab values or other related results.**

Data Time Frame:       through

Gender:  Female  Male  Both

Inclusive ages:       to

Other Criteria:

Date data required:

I agree to abide by the guidelines set forth by the Health Information Management Department, the Pathology Department and/or the Institutional Review Board for the review and receipt of protected health information. I also agree that if anytime in the future I decide to publish this information or present it outside of the University of Notre Dame, I will obtain prior approval from the Institutional Review Board.

Requestor Signature Date