UTMB REQUEST FOR RESEARCH DATA

Please check:  □ Health Information Management  □ Pathology Laboratory Information Services
□ Information Services  □ Other ____________________________

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.

Signature: ______________________________________ Date: __________________

Name of Requestor: ____________________________ □ Faculty □ Staff □ Resident □ Intern
□ Student □ Hospital Employee

Department: ____________________________ Ext: __________________

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.

1. ________________________________________________________________________________________________
2. ________________________________________________________________________________________________
3. ________________________________________________________________________________________________
4. ________________________________________________________________________________________________
5. ________________________________________________________________________________________________
6. ________________________________________________________________________________________________
7. ________________________________________________________________________________________________

Data Time Frame: ____________________________ Specification:  Sex: □ Male □ Female □ Both

Inclusive Age Groups: ____________________________ Other: ____________________________

Deadline Date: ____________________________ Data/Records Needed By: ____________________________

I agree to abide by the guidelines set forth by the Health Information Management Department, the Pathology Department and 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 UTMB; I will obtain prior approval from the Institutional Review Board.

Signature of Authorized Requestor (Original signature required) __________________________________________

Form RRD01-7/04 (for additional forms go to https://my.utmb.edu/eforms/view_print_eforms_general.asp)