



RESEARCHER CERTIFICATION FOR PHI OF DECEDENTS

This form must be completed by any researcher seeking access to a decedent's protected health information for research on that decedent.

Researcher Name: _____
Last First MI

INFORMATION REQUESTED

Please describe in the space below the protected health information [including the name of the decedent(s)] you would like to review.

SPECIFIC REPRESENTATIONS

I seek access to the above protected health information solely for research on the protected health information of the decedent(s) named above. I understand that I may not request a decedent's medical history to obtain information about another living person such as a decedent's living relative.
I affirm that access to the above protected health information is necessary for my research purposes.
I agree to provide, at the Research Foundation's request, documentation of the death of the decedent(s) named above.

By signing below, I represent that all of the above statements are true.

Print Name of Researcher

Signature of Researcher

Date