SUNY DOWNSTATE Medical Center

HIPAA WAIVER OF AUTHORIZATION FORM

Principal Investigator: _____ Study Title: _____

PART A- ***To be completed by the Principal Investigator***

1. Provide a brief description of the individual's identifiable health information (IIHI) for which you are requesting access to or use of without patient authorization:
   _____
   _____
2. Describe your plan to protect identifiers from improper use or disclosure. This plan must be adequate and should indicate where the IIHI will be stored and who will have access to it (ie., Sponsor, OHRP, FDA, Data Safety Monitoring Boards, Research team as listed on IRB application):
   _____
   _____
3. Describe your plan to destroy the identifiers at the earliest opportunity consistent with the conduct of research, unless there is a health or research justification for retaining the identifiers or retention is required by law:
   _____
   _____
4. Provide an explanation as to why the research cannot practicably be carried out without the waiver:
   _____
   _____
5. Provide an explanation as to why the research cannot practicably be conducted without access to and use of IIHI:
   _____
   _____

My signature below assures that the IIHI will not be reused or disclosed to any other person or entity, except as required by law or for other research specifically approved by the IRB.

_____ _____

Principal Investigator Signature Date

PART B- ***To be completed by the IRB***

☐ Approved ☐ Denied; Reason for Denial: _____

_____ _____

IRB Chair Signature/ Designee Signature Date of Review