

Date: _____

CERTIFICATION FOR RESEARCH
ON THE PROTECTED HEALTH INFORMATION OF DECEDENTS

Your Name: _____
Please print or type

Your contact information at work: Office location _____
 Telephone number _____
 E-mail address _____

Title of research protocol: _____

IRB protocol #: _____

Source(s) of decedent's information: _____

I acknowledge that this certification applies to the use of protected health information (PHI) when my research protocol, or a distinct part of that protocol, is directed at decedents. I also acknowledge that the HIPAA Privacy Rule [45 CFR 164.512(i)(1)(iii)] imposes the following rules on my use of decedent's PHI from the source named above.

1. This certification permits me to use PHI of decedents only for research in the protocol named above.
2. At the request of an IRB or an official of any institution within the covered entity, I will provide documentation of the death of any individuals whose PHI I am seeking to use in the research protocol named above.
3. My use of the PHI of decedents is necessary for the purposes of carrying out the research protocol named above.

I certify that I will apply the rules written above to my research use of the PHI of decedents.

Signature

Date

Filing Instructions: A copy of this form should be filed with the UW Privacy Officer, 90 Bascom Hall, 500 Lincoln Drive, Madison, WI 53706-1380; and with the appropriate UW IRB. Please keep a copy for your own records, as you may be asked by the covered entity to verify that you have signed the certification.