# IRB – REQUEST FOR WAIVER OR ALTERATION OF HIPAA AUTHORIZATION AND WRITTEN INFORMED CONSENT FOR RESEARCH – FORM D

Title of Project: _____

MWU ORSP FILE #: _____

Principal Investigator: _____
(must have faculty appointment)

Signature of PI: _____

Co-investigators:

_____ _____
_____ _____
_____ _____
_____ _____

Location(s) of Research (Include all locations for all study related activities):

_____

For a research project to qualify for waiver of informed consent and waiver of HIPAA authorization, all of the following requirements must be met. Please submit information on how your project fulfills each of these requirements. Additionally, the investigator's certification on page 2 of this form must be completed and attached to a completed Form A.

1. The research is minimal risk.

   _____

2. Research could not be practicably conducted without waiver or alteration.

   _____

3. Research could not be practicably conducted without access to the protected health information sought.

   _____

4. The waiver or alteration will not adversely affect the rights and welfare of subjects

   _____

5. Disclosure involves no more that minimal privacy risk to the individual.

   _____

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6. Adequate plan to protect protected health information from improper use and disclosure.

   _____

7. Adequate plan to destroy the identifiers at the earliest opportunity consistent with the conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law.

   _____

8. The private health information disclosed and used pursuant to this waiver will be the minimum necessary to accomplish the goals of the study.

   _____

9. Whenever appropriate, the subjects will be provided with additional pertinent information after they have participated in the study.

   _____

10. Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity (except as required by law or for the authorized oversight of the research project.)

    _____

## INVESTIGATOR'S CERTIFICATION

My signature below indicates that I certify that the protected health information accessed by this study will not be reused or disclosed to any other person or entity (except as required by law or for authorized oversight of the research project).

_____
Printed Name

_____ _____
Signature Date