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|  | Certification of Research on Decedents’ Only PHI |

**Purpose of this Certification Form**

This form is to be used to request access to obtain protected health information (PHI) of decedents from an FIU Covered Entity pursuant to Policy #2370.521, HIPAA & Research: Certification for Research Using Decedent Protected Health Information. Please refer to that policy for capitalized terms in this form that are not herein defined.

**Instructions for Submitting this Certification Form**

1. Submit this completed form to the HIPAA Security Administrator of the respective FIU Covered Entity from which the decedent PHI is being requested.
2. That Covered Entity’s HIPAA Security Administrator will approve or deny the form.
3. If approved by the HIPAA Security Administrator, the investigator must submit a copy of the approved form to the Office of Research Integrity via ori@fiu.edu for filing purposes.

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| **Administrative Information** |
| Project Title: |  |
| Investigator Name: |  |
| Department: |  |
| Phone Number: |  |
| Email Address: |  |
| Funding Source: |  |

The investigator makes the following certifications:

1. I wish to conduct research on:      .

<*Investigator must briefly describe the proposed protocol in a way that sufficiently justifies the need for access to decedents’ PHI*>

1. To conduct the above-described research, I require access to the following PHI of decedents:

*<Investigator must specify the particular database, class of patient records, HIPAA identifiers, etc.)>*
2. I certify I will access only decedents’ PHI pursuant to this certification and that I will only access information for individuals who are deceased on or before:      .
3. I understand that I may not request a decedent's medical history to obtain information about another living person(s), such as a decedent's living relative(s).
4. If requested, I will provide documentation of the death of the individuals whose PHI I am accessing pursuant to this certification.
5. This certification for research on decedents’ PHI will commence on the Approval Date noted below and will expire on the Expiration Date noted below. After that Expiration Date, I will no longer be permitted to access or use the decedents’ PHI for review/research purposes.
6. I represent that all of the above statements are true.

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| Signature of Investigator |  | Date |

**FOR FIU COVERED ENTITY USE ONLY**

Name of FIU Covered Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This certification is: Approved Denied

Signature of HIPAA Security Administrator Approval Date

Name of HIPAA Security Administrator Expiration Date