THE UNIVERSITY OF ARIZONA

Request for De-Identified Information

Requestor Name_____Title_____

Department/Organization_____

Address_____
Street City State ZIP

Business Phone (____)_____ Email_____

Date Information is Needed_____

A. Purpose of the Request:

B. Will the De-Identified Information be used or accessed by someone other than the requestor?

☐ Yes ☐ No

If Yes, list by name (or title) the individuals who will use or have access to this information:

Name/Title	Department	Phone Number

HPP Use Only:
HIPAA Privacy Program
v. 2015

C. Describe the parameters or selection criteria needed to process this request for De-Identified Information (e.g., diagnosis, procedure, drug use).

Time Period	Min. Number of Records	Selection Criteria	Type of Patient Record

D. Describe or attach the requested format (and record layout parameters) of the information (i.e., hard copy, electronic, etc.)

Time Period	Min. Number of Records	Selection Criteria	Type of Patient Record

E. Describe or attach the requested format (and record layout parameters) of the information (i.e., hard copy, electronic, etc.):

F. List any planned publications that will result from use of the information provided:

Will you ever need to determine the identity of any of the individuals included in the De-Identified Data Set?

☐ Yes ☐ No

If Yes, please explain how often and why:

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ AND AGREE TO ABIDE BY THE FOLLOWING REQUIREMENTS FOR USE AND DISCLOSURE OF THE DE-IDENTIFIED HEALTH INFORMATION YOU ARE REQUESTING.

1. The recipient(s) will not give, sell, loan, show or disseminate the de-identified information to any parties other than those listed in item B above, without the express written permission of UA.
2. The recipient(s) will not link the UA De-Identified Data to any other data that the recipient may have access to, where the linked data identifies the individual patients. For example, linking de-identified data from UA with publicly available census data and the linkage reveals the identity of individual patients.
3. If the recipient accidentally identifies an individual, the recipient will not retain such identification and will not contact any patient, or their relatives, employers, or other household members.

Requestor Signature: ____ Date of Request: _____________

Printed Name: ____

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FACILITY USE ONLY: [ ] APPROVED [ ] DENIED

If denied, reason:

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If approved:

1. The requestor of the de-identified data agrees to pay the established fees: ☐ YES ☐ NO
2. Appropriate fees have been collected: ☐ YES Amount Paid: $______________________________
3. De-identification Method to be Used: ☐ Statistical Model ☐ Removal of Direct Identifiers
4. Department/Organization to Perform the De-identification: _______________________________
5. Date PHI was De-identified and Delivered to Requestor: __________________________________

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Request Approved by:

Signature: _____ Date: _____

Printed Name/Title: _____

Department: _____

Signature of HIPAA Privacy Officer: _____ Date: _____