# Application for Research on Decedent’s Information

## Submission Instructions

Our website provides full instructions on submitting applications to the IRB: <http://irb.med.nyu.edu/esubmission> Please contact the IRB office at 212 263-4110 with any questions.

## Administrative Information

|  |  |  |  |
| --- | --- | --- | --- |
| Study# |  | Date of this request |  |
| Study Title |  | | |
| Department |  | Division |  |

## Information Being Requested

|  |  |
| --- | --- |
| Describe the information being requested |  |
| Name the Decedent(s) |  |
| Describe the Protected Health Information you are requesting to review | Names (individual, employer, relatives, etc.)  Address (street, city, county, precinct, zip code (initial 3 digits if geographic unit contains less than 20,000 people, or any other geographical codes)  Telephone and fax numbers  Social security numbers  Dates (except for years)  Birth date  Admission date  Discharge date  Date of death  Ages >89 and all elements of dates indicative of such age (except that such age and elements may be aggregated into a category “Age >90”)  E-mail addresses  Health plan beneficiary numbers  Account numbers  Certificate/license numbers  Vehicle identifiers and serial numbers (e.g., VINs, license plate numbers)  Device identifiers and serial numbers  Web universal resource locators (URLs)  Internet protocol (IP) address numbers  Biometric identifiers (e.g. finger or voice prints)  Full face photographic images) and any comparable images  Any other unique identifying number, characteristic, or code; describe: |
| Give a brief description of the nature and purpose of your research |  |

## PI’s Agreement

By checking each box below, I hereby represent the following to be true:

That the use or disclosure is sought solely for research on the Protected Health Information of decedents. I will not request a decedent’s medical history to obtain information about another living person, such as a decedent’s living relative.

That I will provide documentation, at the request of the covered entity, of the death of any individual whose PHI I receive for this research; and

That the Protected Health Information for which use or disclosure is sought is necessary for my research purposes.

## PI’s Signature

|  |  |
| --- | --- |
| Date |  |
| Print Name |  |
| Signature | I certify that access to the above Protected Health Information is necessary for my research purposes, and that I will carry out the proposed data collection in compliance with the representations made above.  I agree to provide, at the request of the Privacy Officer/IRB, documentation of the death of the decedent(s) named above. |

## IRB Chair’s Signature

|  |  |
| --- | --- |
| Date |  |
| Board Name |  |
| Print Name |  |
| Signature | The Office of the Institutional Review Board (“IRB”) has determined that this request for access to protected health information (“PHI”) satisfies the requirements of the HIPAA Privacy Rule. |