



Certification for Research on the Protected Health Information of Decedents

Date: _____

Please print or type: Name: _____
Office Location: _____
Phone: _____
E-mail: _____
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 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 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: Submit a signed and dated copy of this form to the appropriate UW IRB, HIPAA Privacy Officer and to the administrator of your department, section, center, or institute. You may submit your completed form electronically to the Privacy Officer at hipaa@wisc.edu, or by mail at:

UW-Madison HIPAA Privacy Officer
361 Bascom Hall, 500 Lincoln Drive
Madison, WI 53706

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.