



## Opus Institutional Review Board

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### Application for HIPAA Waiver of Authorization

#### Protocol Information

|  |                        |
|--|------------------------|
|  | Protocol Name          |
|  | Site                   |
|  | Sponsor                |
|  | Principal Investigator |
|  | Phone #                |
|  | Email Address          |

#### Answer all the following questions completely. Upload or attach additional pages if necessary.

Explain below why the waiver is necessary for this protocol at your site. Why the research could not practically be conducted without the alteration or waiver of authorization

Explain below why the research could not be conducted without access to and use of the protected health information (PHI).

Describe the possible benefits of the research to:

The general population

The group of individuals whose PHI you propose to use or disclose

What are the possible privacy risks to individuals whose protected health information will be used or disclosed? Explain below:

Describe below, your site's plan to protect the identifiers from improper use or disclosure.

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Please describe below, your site's plan to track use of PHI.

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Describe your plan to destroy the identifiers. If there is no intent to destroy the identifiers, please justify your retention of this information. Are there any legal mandates for such retention? Explain below:

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Detail your security steps to protected health information so it will not be used or disclosed to any other person or entity, (except as required by law, for authorized oversight of the research project or for other research for which the use or disclosure of PHI would be permitted by regulation). Please explain below:

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Who is the Privacy Officer at your institution? Please give their contact information below. Example: Name, Title, phone number, email

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Please upload or attach a copy of your standard operating procedures regarding privacy and HIPAA regulations.

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Who can OPUS IRB contact for further information?

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**As principal investigator, I certify that the information above is completely accurate and complete to the best of my knowledge. I have read the regulations and I understand my responsibilities and requirements for using and disclosing protected health information which is found in the HIPAA privacy rule under 45 CFR parts 160 and 164.**

Principle Investigator (printed/typed)

\_\_\_\_\_  
Principle Investigator Signature

\_\_\_\_\_  
Date