Certification for Research on the Protected Health Information of Decedents

University of Wisconsin—Milwaukee

Date: _____ Name: _____

Your contact information at work: Office location _____
Telephone number _____
E-mail address _____

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 [45 CFR 164.512(i)(1)(iii)] 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 any institution within 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**: A copy of this form should be filed with entity from where the PHI has been obtained. 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.*