University of Missouri – St. Louis Institutional Review Board

Waiver or Alteration of HIPAA Authorization*

Principal Investigator (PI)		**IRB #:**	
	First Name / Last Name *Credentials*		
Title of Project:			

a) Please provide a brief description of the protected health information for which use or access has been determined to be necessary.

b) To obtain approval for a waiver or alteration of HIPAA authorization for the use and/or disclosure of PHI resulting from participation in a research study, the project has to meet the criteria listed below. Please explain how your study meets these criteria.

1) The use or disclosure of PHI involves no more than minimal risks to the privacy of individuals.

2) PHI information will not be reused or disclosed to any other person or entity, except as required by law for authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted by HIPAA.

3) The research could not practicably be conducted without the waiver or alteration.

4) The research could not practicably be conducted without access to and use of PHI.

c) Please describe an adequate plan to protect any identifiers from improper use and disclosure.

d) Please describe an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law.

The information listed in the waiver application is accurate and all research staff** will comply with the HIPAA regulations and the waiver criteria. All research staff will complete HIPAA training before commencement of this study.

I assure that the information I obtain as part of this research (including protected health information) will not be reused or disclosed to any other person or entity other than those listed on this form, except as required by law. If at any time I want to reuse this information for other purposes or disclose the information to other individuals or entity I will seek approval by the IRB.

Signature of Principal Investigator (PI)	**Date**
First Name / Last Name *Credentials*	
Printed Name of Principal Investigator (PI)	

*HIPAA Regulations allow IRBs to waive use of authorization form if all of the criteria listed above are met. **Note: Research staff is defined as ALL study personnel (including PI) that is involved in the research.