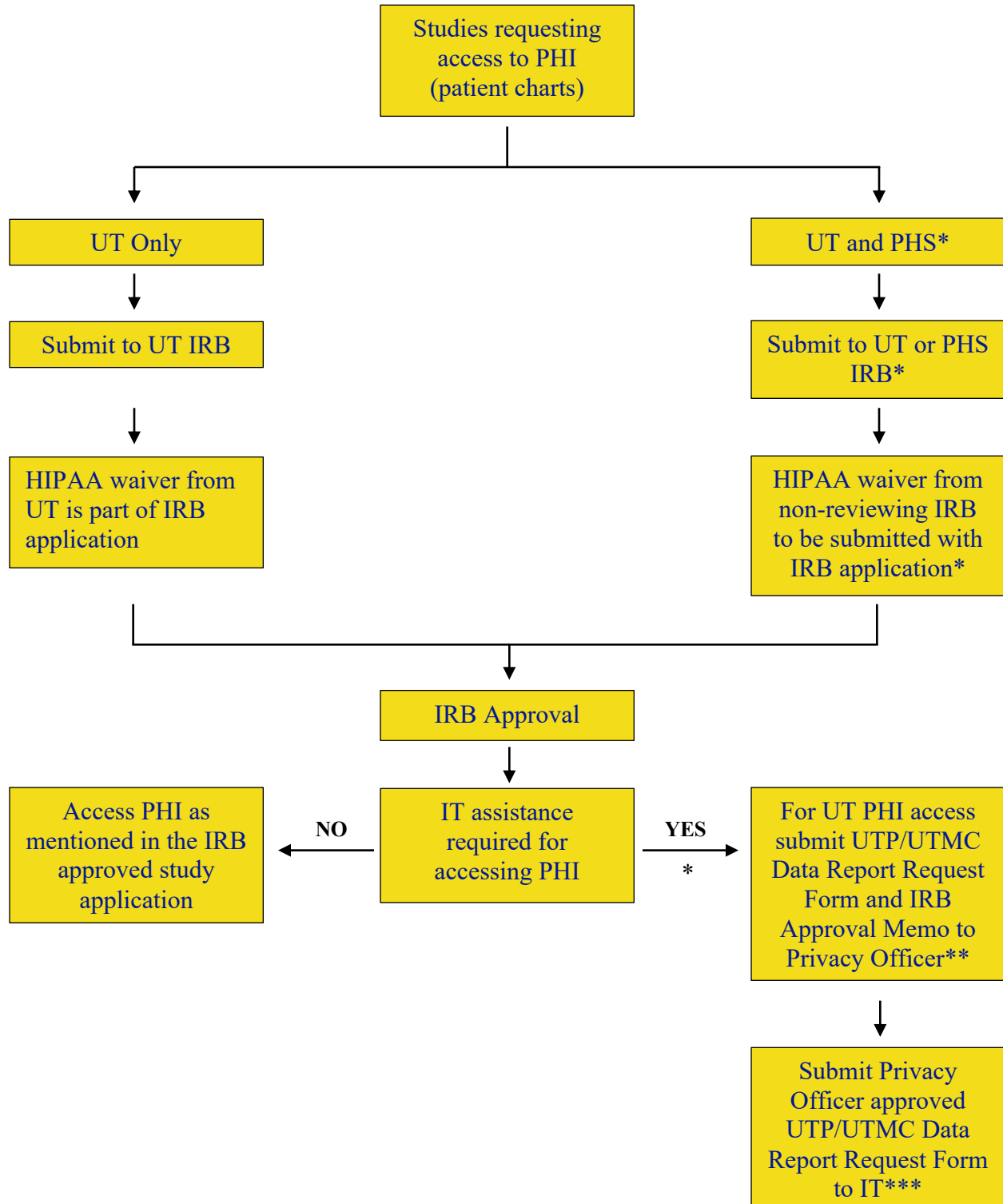# Guidance for studies accessing Protected Health Information (PHI) using HIPAA waiver at The University of Toledo (UT) only/and ProMedica Health System (PHS)*

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                    ┌─────────────────────┐
                    │  Studies requesting │
                    │   access to PHI     │
                    │  (patient charts)   │
                    └─────────────────────┘
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Studies requesting access to PHI (patient charts)

UT Only → **Submit to UT IRB** → **HIPAA waiver from UT is part of IRB application**

UT and PHS* → **Submit to UT or PHS IRB*** → **HIPAA waiver from non-reviewing IRB to be submitted with IRB application***

IRB Approval

IT assistance required for accessing PHI

NO → **Access PHI as mentioned in the IRB approved study application**

YES * → **For UT PHI access submit UTP/UTMC Data Report Request Form and IRB Approval Memo to Privacy Officer**** → **Submit Privacy Officer approved UTP/UTMC Data Report Request Form to IT*****

*For studies accessing PHI at PHS only, ProMedica IRB submission, PHS HIPAA waiver and PHS procedure after IRB approval, contact phsirb@promedica.org

**email: privacyoffice@utoledo.edu

***email: UtpReportRequests@UToledo.edu for outpatient clinical data AND/OR ITHelpDesk@UToledo.edu for inpatient clinical data

UTP/UTMC Data Report Request Form
Email Completed/Approved Form To: ITHelpDesk@UToledo.edu or UTPReportRequests@Utoledo.edu
When submitting request, please use subject line of email to give a brief description of request

THE UNIVERSITY OF **TOLEDO** 1872

Under the Part 2 program, reports that contain Part 2 patient identifying information are protected under the Part 2 regulations. Patient consent must be obtained to provide the information and/or IRB approval. These reports may not be re-disclosed without authorization. Consult with Office of Legal Affairs or the Privacy Office for direction.

Requestor Information:

_____   _____   _____

Name   Phone   Date

_____   _____

Department   Title

_____   _____

Report being Requested on Behalf of   Date Final Report Needed **(DO NOT use ASAP)**

Purpose and Outcome of Report

	Billing Inquiry / Verification		Research (include IRB#: _____)attach copy of IRB approval memo
	Quality Improvement Project		Grant (Please attach copy of grant to this request)
	Provision of Clinical Services		Other (Please Specify)

If any of the Direct Identifiers as described by HIPAA Regulations as listed below are requested, provide an explanation of why you cannot complete the project without these direct identifiers. Follow Minimum Necessary Guidelines and only request what is absolutely necessary.

	PT Name		Certificate/License #		PT MRN		ICD Code		Charges
	Date of Birth		Device/serial #		Acct Number		CPT Code		Payments
	Address/Phone #		Vehicle Identifiers		Phys. Name		HCPCS Code		Adjustments
	Email address		Full Face Photo		Phys. Number		Claim Number		WRVU's
	SSN		Date of Death		Date of Service				
	Insurance Carrier/ID		Other Unique Identifiers		Service Dept.				
	EMR		**Athena**		**STAR**		**Horizon**		**Other**

Give a complete explanation of why you cannot complete the project without these direct identifiers: _____

_____

Please list or attach an example of expected outcome._____

Report can be limited to the following:

Date(s) of Service _____

Date(s) of Transaction _____

Dept. Name/# _____Facility Name/# _____

Full Provider Names _____

Procedure Code(s) (CPT) _____

Diagnosis Code(s) (ICD) _____

Where will the report be securely housed_____ **How long**_____

Plans for destruction of the report_____

Additional Information maybe attached to this request to further explain the report request. IT will not process without approvals.

Supervisor Approval _____   **Date**_____

Privacy Officer Approval: _____ _   **Date** _____

Reason for Denial: _____