

INFORMATION REQUEST

University of Utah Health Sciences Center

This form can be provided to a departmental representative with access to the data, or it can be faxed to ITS at (801) 581-7834. **Do not use this form for research preparation or research on decedents' information. See IRB for proper form.**

Name and PS# ¹ of Person Requesting Records:	Email:	Phone:																									
Contact Person (if different from requester):	Email:	Phone:																									
Campus Address:		Dept:																									
Names and PS#s of persons to have access:																											
<p>1. Purpose of request: <i>(No form is needed for treatment or payment purposes.)</i></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> QA/QI</td> <td><input type="checkbox"/> Audit</td> <td><input type="checkbox"/> Teaching/training</td> <td><input type="checkbox"/> Fundraising⁴</td> </tr> <tr> <td><input type="checkbox"/> Accreditation</td> <td><input type="checkbox"/> Continuity of Care²</td> <td><input type="checkbox"/> Patient newsletter/education³</td> <td><input type="checkbox"/> Marketing</td> </tr> </table> <p><input type="checkbox"/> Research (Attach copy of consent form); IRB number: Other, specify:</p>			<input type="checkbox"/> QA/QI	<input type="checkbox"/> Audit	<input type="checkbox"/> Teaching/training	<input type="checkbox"/> Fundraising ⁴	<input type="checkbox"/> Accreditation	<input type="checkbox"/> Continuity of Care ²	<input type="checkbox"/> Patient newsletter/education ³	<input type="checkbox"/> Marketing																	
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2. Will the patient(s) be contacted? <input type="checkbox"/> Yes; <input type="checkbox"/> No. Purpose:																											
3. Will this information be used in a formal presentation or publication? <input type="checkbox"/> Yes; <input type="checkbox"/> No.																											
4. Location of records requested (Allegra, IDX, etc.):																											
5. Time period of records: From to .																											
<p>6. Data elements requested:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> DX</td> <td><input type="checkbox"/> Proc. Yr.</td> <td><input type="checkbox"/> Admit Yr.</td> <td><input type="checkbox"/> Pt Name/Initsl*</td> <td><input type="checkbox"/> DOB*</td> </tr> <tr> <td><input type="checkbox"/> DRG</td> <td><input type="checkbox"/> Proc. Date+</td> <td><input type="checkbox"/> Admit Date+</td> <td><input type="checkbox"/> Pt Postal Addr*</td> <td><input type="checkbox"/> Age+</td> </tr> <tr> <td><input type="checkbox"/> Procedure</td> <td><input type="checkbox"/> Acct No.*</td> <td><input type="checkbox"/> Disch. Yr.</td> <td><input type="checkbox"/> City, State, Zip+</td> <td><input type="checkbox"/> Age in yrs &</td> </tr> <tr> <td><input type="checkbox"/> Device No.*</td> <td><input type="checkbox"/> MRN*</td> <td><input type="checkbox"/> Disch. Date+</td> <td><input type="checkbox"/> 3-digit Zip⁵</td> <td><input type="checkbox"/> >89 in one group⁶</td> </tr> <tr> <td><input type="checkbox"/> SSN*</td> <td><input type="checkbox"/> Insur. ID No.*</td> <td><input type="checkbox"/> email addr*</td> <td><input type="checkbox"/> Telephone No.*</td> <td><input type="checkbox"/> Full face photo*</td> </tr> </table> <p><input type="checkbox"/> +Other elements that include potentially identifying numbers, characteristics, or codes, except as permitted for re-identification under HIPAA⁷ (please specify): <input type="checkbox"/> Other non-identifying elements (please specify):</p> <p>* Disqualifies info from being de-identified or a Limited Data Set under HIPAA. + Disqualifies info from being de-identified under HIPAA. May be part of a Limited Data Set.</p>			<input type="checkbox"/> DX	<input type="checkbox"/> Proc. Yr.	<input type="checkbox"/> Admit Yr.	<input type="checkbox"/> Pt Name/Initsl*	<input type="checkbox"/> DOB*	<input type="checkbox"/> DRG	<input type="checkbox"/> Proc. Date+	<input type="checkbox"/> Admit Date+	<input type="checkbox"/> Pt Postal Addr*	<input type="checkbox"/> Age+	<input type="checkbox"/> Procedure	<input type="checkbox"/> Acct No.*	<input type="checkbox"/> Disch. Yr.	<input type="checkbox"/> City, State, Zip+	<input type="checkbox"/> Age in yrs &	<input type="checkbox"/> Device No.*	<input type="checkbox"/> MRN*	<input type="checkbox"/> Disch. Date+	<input type="checkbox"/> 3-digit Zip ⁵	<input type="checkbox"/> >89 in one group ⁶	<input type="checkbox"/> SSN*	<input type="checkbox"/> Insur. ID No.*	<input type="checkbox"/> email addr*	<input type="checkbox"/> Telephone No.*	<input type="checkbox"/> Full face photo*
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7. List type of information that is being requested:																											

¹ PeopleSoft number.

² E.g., provider leaving the University wants to contact current/former patients.

³ You MUST include a full copy of the patient newsletter/education with this request.

⁴ Request may include only name, address and other contact information, age, gender, insurance status, and dates of health care service.

⁵ All data from the following 17 3-digit Zip codes must be combined together under "000" to be de-identified under HIPAA: 036, 059, 063, 102, 203, 556, 692, 790, 821, 823, 830, 831, 878, 879, 884, 890, and 893.

⁶ Ages over 89 must be combined in a single category of "Age 90 and older" to be de-identified under HIPAA.

⁷ See Safe Harbor or Statistical Analysis De-identification for info on re-identification requirements.

8. Specific diagnoses or procedures requested for search:

9. Identify which patient population you want the data elements pulled from (Note: Attach a separate sheet to specify, if necessary.):

<input type="checkbox"/> University Hospital (Inpatient)	<input type="checkbox"/> University Neuropsychiatric Institute (UNI)
<input type="checkbox"/> Community Clinics	<input type="checkbox"/> Sugarhouse Clinic <input type="checkbox"/> Madsen Clinics
<input type="checkbox"/> Moran Eye Center	<input type="checkbox"/> University Orthopædics Center
<input type="checkbox"/> Huntsman Cancer Hospital	<input type="checkbox"/> Huntsman Cancer Institute
<input type="checkbox"/> Outpatient Clinic(s): _____	
<input type="checkbox"/> Specific Provider(s): _____	
<input type="checkbox"/> Other Specify: _____	

10. How does this request comply with HIPAA?

- This is for healthcare operations⁸, as defined by HIPAA.
- I have signed authorization from all patients. (Attach sample authorization.)
- I have an IRB-approved waiver or modification of authorization.
- I am requesting a Limited Data Set. (Attach Limited Data Set Statement and Assurance.)
- I am requesting de-identified data. (Attach Safe Harbor or Statistical Analysis De-identification)⁹
- Other (explain): _____

11. Will Protected Health Information¹⁰ be disclosed outside the University's covered entity?
 Yes; No.

12. **REQUESTER'S REPRESENTATION**
 By signing this form I affirm the following:

- I seek to review the indicated information solely for the purposes indicated;
- The information for which I seek use or access is the minimum necessary for the purpose of this request.

13. Requester's signature:	Date:
14. Requester's position:	
15. Signature of Dept. Chair, Attending Physician, or Responsible Faculty Member: _____ Printed name: _____	Date:

INFORMATION REQUEST (For Admin Use Only)

This information request has been reviewed and approved by:

Privacy Office; IRB (for Research); Health Information; ITS; Dept. Rep.

Date Approved: _____ By: _____

Original: Kept by Approving Individual
 Copy to HIPAA Privacy Office, 50 N. Medical Dr.; or fax to 587-9443

⁸ *Health care operations* include quality assessment and improvement, training, accreditation, certification, licensing, medical review, legal services, auditing functions, business planning and development, and business management and general administrative activities; and exclude research. 45 CFR 164.501.

⁹ If your request involves an unusual disease or condition, attach a statement explaining 1) the incidence of the disease or condition and 2) the potential of the information in your request to be used to identify the individuals.

¹⁰ *Protected Health Information (PHI)* is information about the past, present, or future physical or mental health of an individual that identifies or could be use to identify the individual and is created or received by a Covered Entity. (45 CFR 160.301, 164.501; information about the provision of health care and payment for health care is included; some educational and employment records are excluded.)