Request for Waiver of Authorization

1. Protocol title:

2. eProst Number

3. Purpose for this Request:

To identify potential subjects for recruitment

Other. Please describe:

4. Describe the information that will be obtained from the EMR:

Confirm that you will destroy the Protected Health Information (PHI) you and/or your Study Team acquire receive from JHS and/or UHealth at the earliest opportunity.

*I confirm*

Confirm that the Protected Health Inform (PHI) you acquire from JHS and/or UHealth will not be re-used or disclosed to any other person or entity, except as required by law or for authorized oversight of the research study or for other research for which the use or disclosure of PHI is permissible.

*I confirm*

If data will be collected from JHS, you read and agree to the following:

I agree to store JHS data, including Protected Health Information (PHI) and/or Personally Identifiable Information (PII), acquired from JHS for this research on the secured JHS SharePoint environment made available by JHS. I and the Study Team members shall not copy or store the JHS sourced personally identifiable information (PII), including protected health information (PHI) data to any other system, including any systems maintained or provided by the University of Miami. I and the Study Team shall only copy or transfer JHS-sourced data that has been properly de-identified in accordance with all requirements contained in the HIPAA Rules by removing all of the identifiers listed in the instructions under the Confidentiality Section 4 of this protocol.

Notwithstanding the preceding “I confirm” statements above, I agree that neither I nor any member of the study team listed on the IRB submission for this Protocol shall ever re-use or re-disclose any of the information acquired from Jackson Health System in any format, whether **identifiable or de-identified,** to any individual or entity without first obtaining written permission from Jackson Health System, even if such re-use or re-disclosure is permissible by law (e.g., HIPAA).

**PI Name:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**