



HOSPITALS · RESEARCH · FOUNDATION

## Certification for Access, Use and Disclosure of Protected Health Information of Deceased Individuals Form

Name:  
Department:  
Phone number:  
Date:

Please list the Protected Health Information (PHI) needed:

Describe the purpose of requested PHI:

Will the PHI be disclosed to anyone outside of Arkansas Children's, and if so, who:

Attestation:

- The use or disclosure sought is solely for research on the protected health information (PHI) of decedents;
- The Investigator will provide proof of death if requested; and
- The PHI for which use or disclosure is sought is necessary for the research purposes.

\_\_\_\_\_  
Investigator Signature

\_\_\_\_\_  
Date

Completed forms should be emailed to [HollowayAG@archildrens.org](mailto:HollowayAG@archildrens.org).

\*This form will be submitted to the Arkansas Children's Privacy Board for review and approval.