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