BOSTON UNIVERSITY
Boston University Henry M. Goldman School of Dental Medicine
Office: 617-358-6100 | GSDMComp@bu.edu

Request for Access for Activities Preparatory to Research

Fillable Form Instructions: Complete and submit this form to the HIPAA contact at GSDMComp@bu.edu.

Applicant BUID

Applicant Name

PI/Assistant Researcher/Mentor

Date of Request

Email Address

Department/Program & University

Telephone

Select your role: Select one

Does the request involve records with special protection (i.e. Alcohol or substance abuse, HIV, Mental Health)? Select one

Describe patient PHI to be reviewed:

Purpose of Review:

Time period of preparation (default is 6 months):

Describe the preparation tasks requiring PHI:

- ☐ **Determine number of potential subjects**
- ☐ **Locate images or procedures**
- ☐ **Prepare a proposal or protocol**
- ☐ **Prepare IRB application**
- ☐ **Other:**

Which database(s) will you be accessing?

- ☐ **Salud/Eaglesoft**
- ☐ **Dolphin Images**
- ☐ **MiPacs Radiographs**
- ☐ **CBCT Images**
- ☐ **Other:**

Note: Preparatory research activities involving contact with prospective research subjects for recruitment purposes is not covered or permitted by this form. Any recruitment activities that involve contacting prospective research subjects must first be reviewed and approved by the IRB.

I assure the Henry M. Goldman School of Dental Medicine (GSDM) that I will access the records described above in order to prepare a research protocol, or other similar activities related to preparing for research. In compliance with HIPAA, I assure GSDM of the following:

1. I will use the PHI described above solely to prepare a research protocol or for similar purposes preparatory to research.
2. The PHI described above is necessary to develop the research protocol or other activities preparatory to research.
3. Neither I nor anyone working with me will remove any PHI from the GSDM site or resources.
4. The PHI in notes/media form will be stored onsite at a GSDM secure location or in electronic form on a GSDM HIPAA network drive (i.e., busdm-ph, not cloud storage such as Teams/SharePoint, OneDrive) and will be destroyed when no longer needed.
5. **I will not contact patients for purposes of recruitment or for any other reason, unless it is to provide patient care and they are my patient.**

Requestor Signature

Date

Faculty Supervisor Signature

Faculty Supervisor Name

Date

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For office use only:

HIPAA Contact Signature

HIPAA Contact Name

Date

Adjustments to request (please initial):

Completed by Dent IT:

DentIT Staff Name

DentIT Date

Note: A copy of this form will be shared with BU Dental School Research Office.