

Request for Access for Activities Preparatory to Research

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

Applicant BUID	Applicant Name	PI/Assistant Researcher/Mentor	Date of Request
Email Address		Department/Program & University	Telephone
Select your role:		Does the request involve records with special protection (i.e. Alcohol or substance abuse, HIV, Mental Health)?	

Describe patient PHI to be reviewed:

Purpose of Review:

Time period of preparation (default is 6 months):

Describe the preparation tasks requiring PHI:

Which database will you be accessing?

Determine number of potential subjects
Locate images or procedures
Prepare a proposal or protocol
Prepare IRB application
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 BU HIPAA Covered Component 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 such BU HIPAA Covered Component 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 HIPAA Covered Component site or resources.
4. The PHI in notes/media form will be stored onsite at a secure location or in electronic form on a 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



For office use only:

HIPAA Contact Signature	BU HIPAA Covered Component
HIPAA Contact Name	
Date	
Adjustments to request (please initial):	