

# WIRB®

WESTERN INSTITUTIONAL REVIEW BOARD®  
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## Request for Full Waiver of Authorization under HIPAA

Sponsor \_\_\_\_\_

Sponsor Protocol No. \_\_\_\_\_

### Principal Investigator (PI) Information:

1.	PI Name:		
2.	PI Company Name:		
3.	PI Mailing Address: (street, city, state/province, zip, country)		
4.	PI Phone: (     )	PI Fax: (     )	PI E-mail:
5.	How would the PI prefer to receive study documents? (check one) <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Regular Mail		

### Waiver of authorization to use and disclose protected health information:

1.	Describe the identifiable health information that will be accessed under this waiver:		
2.	Who will have access to the information?		
3.	Are the persons who have access to the information required to sign confidentiality statements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	What identifiers are included on the information you plan to use and/or disclose?		
5.	In what form will the information be maintained? <input type="checkbox"/> Paper <input type="checkbox"/> Electronic <input type="checkbox"/> Both		
6.	If the information is in paper format, describe the precautions you are taking to protect the identifiers from improper use and disclosure:	NA <input type="checkbox"/>	
7.	If information is in an electronic medium, are passwords required?	NA <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	Is access to the information restricted to only those who have a need to know for performance of their job?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Is this electronic system used to transmit data outside of your site?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	If information is transmitted, what safeguards does your system have to prevent inadvertent access to this data?		

**Request for Full Waiver of Authorization under HIPAA (continued)**

11.	When do you plan to destroy the identifiers? ( <b>Identifiers must be destroyed at the earliest opportunity.</b> ) <input type="checkbox"/> End of Study <input type="checkbox"/> _____ years after the end of the study. <input type="checkbox"/> Other (please specify): _____
12.	Other than you and your research staff, who else will have access to this information?
13.	Please explain how your research meets the following criteria for a waiver: 1. This research cannot be practicably carried out without the Waiver of Authorization. _____
	2. This research cannot practicably be conducted without the participants' PHI. _____

**BILLING INFORMATION: Please tell us who should be billed for this review. (If this section is not completed, the PI will be billed)**

1.	Company Name:		
2.	Attn.:		
3.	Address: (street, city, state/province, zip, country)		
4.	Phone: (     )	Fax: (     )	E-mail:
5.	Mail Stop/Cost Center:		
6.	Purchase Order number (P.O.#), if applicable:		
7.	Cost of the requested WIRB translation services will be paid by: (if applicable)		
8.	Please describe any special billing instructions:		
9.	If you have listed someone other than yourself as the billing contact, please attach written verification from that person indicating he or she will pay for these services.		

**By signing this statement, I am providing written assurance that only information essential to the purpose of this research will be collected and used, and protected health information will not be re-used or disclosed to any other person or entity except as permitted under the Privacy Rule found at 45 CFR 64. This written assurance is only applicable to research conducted under the jurisdiction of the Privacy Rule.**

\_\_\_\_\_  
Signature of Principal Investigator

\_\_\_\_\_  
Date