

<b>Form G:</b> <b>RESEARCH INVOLVING PRIVATE HEALTH INFORMATION</b>	<b>For IRB Use Only:</b>	
	<b>IRB No.</b>	Click here to enter text.
	<b>Date Submitted</b>	Click here to enter text.
	<b>Date Approved</b>	Click here to enter text.

All forms and research instruments should be submitted by email to [kraig.knudsen@mh.ohio.gov](mailto:kraig.knudsen@mh.ohio.gov) or you may mail them to: Kraig Knudsen, Ph.D., Ohio Department of Mental Health, 30 East Broad Street, 8<sup>th</sup> Floor, Columbus, Ohio 43214-3430.

<b>TITLE OF RESEARCH:</b>	Click here to enter text.
<b>IRB #:</b>	Click here to enter text.

		<b>DEPT</b>	<b>EMAIL</b>
<b>Principal Investigator</b>	Click here to enter text.	Click here to enter text.	Click here to enter text.
<b>Other Investigator</b>	Click here to enter text.	Click here to enter text.	Click here to enter text.
<b>Other Investigator</b>	Click here to enter text.	Click here to enter text.	Click here to enter text.

1. Does the proposed research involve personally identifiable medical records and/or information that relates to condition, treatment, or payment for treatment?  
 Yes                       No

1b. If yes, does the proposed research involve private health information?  
 Yes                       No

2. Will you secure authorization from subject to use their private health information?  
 Yes                       No  
*(If no, skip to question 4.)*

3. If you are securing authorization to use private health information, you must provide a copy of your informed consent form to the IRB. Does it include:

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A description of the information to be used or disclosed that identifies the information in a specific and meaningful manner?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | The name of the covered entity or person(s) authorized to make the requested use or disclosure?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | The identification of the entity or person(s) to receive the disclosure?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | An expiration date or condition, a signature, and date of signature?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | An authorization written in plain language?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If the authorization is executed by a legal representative authorized to act for the individual, a description of his/her authority to act for the individual specified as well as the relationship to the individual? |

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A statement that the individual acknowledges that s/he has the right to revoke the authorization except to the extent that information has already been disclosed pursuant to the authorization?            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A statement that the individual acknowledges that the information used or disclosed to any entity other than a health plan or a health care provider may no longer be protected by the federal privacy law? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A statement that the individual may inspect or copy the protected health information to be used or disclosed?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A description of the purpose(s) of the requested use or disclosure?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A statement that the individual may refuse to sign the authorization and treatment, etc. is not conditioned on signing?   |

4. Are you securing a waiver or alteration of subject authorization for the use and disclosure of protected health information? *(If yes, complete Form F.)*

- Yes                       No

5. Are you attempting to review the private health information in order to prepare a research project or protocol?

- Yes                       No

6. Are you receiving private health information about deceased individuals?

- Yes                       No

7. Are you using a limited or de-identified data set? *(If yes, complete Form J.)*

- Yes                       No

<b>SIGNATURES:</b>	
_____	_____
Principal Investigator or Student	Date
_____	_____
Faculty Advisor <i>(for student apps)</i>	Date

<b>IRB APPROVED:</b>

IRB Chair or Designee

Date