**South Carolina Department of Mental Health Institutional Review Board (IRB)**

**REQUEST FOR** **WAIVER OR ALTERATION OF INDIVIDUAL AUTHORIZATION UNDER THE HIPAA PRIVACY RULE**

**Request for Waiver [ ]  Partial Waiver [ ]  Alteration [ ]**

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| --- | --- |
| **Title of Research Project:** |  |
| **Principal Investigator:** |  |
| **Telephone Number:** |  |
| **Email Address:** |  |

**1. Provide a brief description of the minimum amount of protected health information for which use or access is necessary.**

 **a. Give an estimate of the number of records that will be involved in the project.**

**2. The use or disclosure of protected health information involves no more than a minimal risk to privacy of the individuals based on, at least:**

 **a. An adequate plan to protect the identifiers from improper use and disclosure. (Describe the plan)**

 **b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research (unless there is a health or research justification for retaining the identifiers)? (Describe the plan)**

**3. Will the alteration or waiver of authorization adversely affect the privacy rights or welfare of the individuals?**

**4. Why can the research not be conducted without waiver or alteration of the authorization?**

**5. Why can the research not be conducted without access to and use of protected health information?**

**6. Are the privacy risks to individuals whose protected health information is to be used or disclosed reasonable in relation to the anticipated benefits if any to the individuals, and the importance of the knowledge that may reasonably be expected to result from the research?**

**Investigator’s Assurance:**

**I assure that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart.**

**Principal Investigator Signature       Date**

**Note: Electronic transmission of this document to the SCDMH IRB (**IRB@scdmh.org **) will be considered a valid signature if originating from the email address of the researcher.**

**Or, the signed form may be mailed to Lynelle Reavis, Ph.D., SCDMH IRB Administrator 2414 Bull Street Suite 302, Columbia, SC 29201.**