Request for De-identified Information

LSUHSC-NO requires a written request for de-identified information that provides a detailed explanation of why the information is required. It is within the discretion of LSUHSC-NO to approve or deny requests for de-identified information. Please complete the following to assist us in the review process. Submit this completed form to LSHUHSC-NO's Privacy Officer at 433 Bolivar St. Room 704, New Orleans, LA 70112.

Requestor
Name:_____Title:_____

Department/Organization:_____

Address:_____
                    Street   City   State   Zip Code

Business Phone: (_____)_____   E-mail: _____

A. Purpose of the Request:
_____
_____
_____

B. Describe the parameters or selection criteria needed to process this request for de-identified information (e.g. diagnosis, procedure, drug use):
_____
_____
_____

C. Time Period _____
        Minimum number of records _____
        Selection Criteria _____
        Type of patient record _____

D. Describe or attach the requested format (and record layout parameters) of the information (i.e., hard copy, electronic, etc.)

F. Will you ever need to determine the identity of any of the individuals included in the de-identified data set?   [ ] Yes   [ ] No
 If Yes, please explain how often and why – be specific:

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ AND AGREE TO ABIDE BY THE FOLLOWING REQUIREMENTS FOR USE AND DISCLOSURE OF THE DE-IDENTIFIED HEALTH INFORMATION YOU ARE REQUESTING.

1.   The recipient(s) will not link the LSUHSC-NO de-identified data to any other data that the recipient may have access to, where the linked data identifies the individual patients. For example, linking de-identified data from LSUHSC-NO with publicly available census data and the linkage reveals the identity of individual patients.
2.   If the recipient accidentally identifies an individual, the recipient will not contact any patient, or their relatives, employers, or other household members.

Requestor Signature: _____ Date of Request___/___/___

Printed Name_____ Date Needed:___ /___/___

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FACILITY USE ONLY: [ ] APPROVED [ ] DENIED

If denied, reason:_____
_____
_____

If approved: _____

The requestor of the de-identified data agrees to pay the established fees:
[ ] Yes [ ] No

Appropriate fees have been collected [ ] Yes   Amount Paid: $_____

De-identification Method to be Used: [ ] Statistical Model [ ] Removal of Direct Identifiers

Department/Organization to Perform the De-identification:
_____

Date PHI was De-identified and Delivered to Requestor:___/___/___

Request Approved by:

Signature: _____**Date ___/___/___**

Printed Name/Title: _____

Department: _____