UCLA HEALTHCARE

REPORT OF DISCLOSURE OF PHI FOR RESEARCH

PHI Tracking system request No: _____

IRB Approval No.:_____

Location: WWH SMH NPH
Outpatient Clinic/ Primary Care Network Clinic _____
(specify clinic/PCN)

Name of Person Disclosing the PHI _____

Phone No. _____Pager No._____

Must be completed if Request Has Not Been Assigned Request No. by PMO prior to disclosure:

Copy of IRB Approval Attached
Copy of Data Use Agreement Attached
Copy of Patient Authorizations Attached
Copy of Confidentiality Agreement attached (Researcher to create DDS or LDS)
Copy of HIPAA Research Training Certificate (Researcher to create DDS or LDS)

Principal Investigator:_____

Address:_____

Phone:_____ Pager:_____

Name of Protocol:_____

Research Sponsor:_____

Address:_____

Phone Number:_____

Data Provided to:_____

Phone:_____ pager:_____

(Forward to the Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, Room CHS BH-265 Los Angeles, CA 90095-7305 or Fax to 310-206-2820)

Charts Disclosed to Researcher: Date Disclosed	Preferred ID No.	Patient Last Name	Patient First name	From Date	To Date	Notes

Non-Chart PHI Disclosed:

Date Disclosed	Preferred ID	Patient Name	Description of PHI	Notes