Directions:

This section must be completed whenever data is requested from HIMS, I/S, Registries or any other existing source. Handwritten forms will not be accepted. Submit completed request to Privacy Office.

Date Completed: / / 20

ChristianaCare

Privacy Office Data Request Form

Privacy Office Received:

Name of Individual Requesting Information

Department:

Office Address:

CCHS Email Address:

Phone: Fax:

Supervisor:

Additional Responsible Individual(s):

Project Name

Project Description

Project GO live date

Brief description of requested information: (Please request only the minimum necessary information for project)

The data requested will be (CHOOSE ONE):

◯ Anonymous ◯ De-identified ◯ Coded ◯ Identifiable

Source of Requested Information:

☐ Database build ☐ Chart Review ☐ Daily report ☐ Shared report ☐ Other (Specify) Please

Specify Other

Name of Database or Registry, if known:

Intended Use of Requested Information

☐ Performance Improvement/QA/QI or other internal-use only project

☐ Creation of a Database/Data Repository

☐ Other (Specify) Please Specify Other

For Database Searches, complete the following

Date Database Search Needed:

Number of Individual Records to examine:

Date Ranges: Start Date End Date

Search Criteria ☐ Male ☐ Female ☐ N/A ☐ birth sex Age range (years)

Race/Ethnicity

If OB/GYN: ☐ Mothers only ☐ Babies only ☐ Both

DRG/ICD/CPT Codes:

Diagnoses

Procedures

Other

Patient Service Type:

◯ In-patient ◯ Out-Patient ◯ ED Patient ◯ Other (Please Specify)

Indicate ALL identifiers that will be **COLLECTED or DISCLOSED**

Collect	Disclose		Collect	Disclose		Collect	Disclose	
☐	☐	Name	☐	☐	Medical Record Number	☐	☐	Account Number
☐	☐	Admission Date	☐	☐	Sex	☐	☐	Race
☐	☐	Age	☐	☐	Discharge Date	☐	☐	Insurance
☐	☐	DRG/ICD Codes	☐	☐	Relative's Name/Address	☐	☐	Employer's Name/Address
☐	☐	Street Address	☐	☐	City	☐	☐	County
☐	☐	Zip Code	☐	☐	Precinct	☐	☐	Birth Date
☐	☐	Date of Death	☐	☐	Health Plan Beneficiary Number	☐	☐	Telephone Number
☐	☐	Fax Number	☐	☐	Social Security Number	☐	☐	Email Address/URLs/IP
☐	☐	Serial Number (Device ID, Vehicle ID, etc.)	☐	☐	Voice Recordings	☐	☐	Fingerprints
☐	☐	Photographs	☐	☐	Certificate/License Number	☐	☐	Other (Specify Below)

Please Specify Other

13) Where will project records be maintained?

14) What format will be used to maintain records? (Choose all that apply)

☐ Electronic ☐ Paper ☐ Disk/CD ☐ Digital (video/films/etc.) ☐ Web-Based ☐ CCHS Issued laptop
☐ CCHS Secure Flash Drive ☐ Other (Please Specify)

Please Specify Other

15) Describe what security measures will be taken to protect data.

16) Describe the plan for retention and destruction of study records following study closure. Include location of storage, time frame and method for destruction and any other applicable information.

Who will have access to the information (Business associate, downstream 3rd party, CCHS caregivers only)?:

I understand that no data may be collected until I have received approval of these procedures from the appropriate department(s). In addition, I understand that I must comply with any required modifications in connection with that approval. Approvals are intended only for the original request. Changes or modifications to the request requires a new Data Request Form submission for approval. I understand that I am to maintain subject data in a secure and safe location and will provide the original data if so requested.

Signature of Data Requestor

Signature of Supervisor/Chair

Date

Date

Privacy Office Action: Approved by and date

POA Number

Comments

Sent to Department Providing Data

Date

Concerns or comments:

This is to be maintained by the privacy office for the duration of the project, destruction notification, and following other retention policies by CCHS