



**SPECIFIC REPRESENTATIONS**

I seek access to the above protected health information solely to prepare a research protocol or for similar purposes preparatory to research.

I will not remove any of the above information from the hospital's premises during the course of my review.

I affirm that access to the above protected health information is necessary for my review preparatory to research.

I understand that I may not record any protected health information in a way that may directly or indirectly be used to identify particular individuals (*e.g.*, names, addresses, telephone numbers, etc.).

I understand that I may not continue to use and disclose the protected health information described above without permission from the IRB once the Principal Investigator has determined to go forward with the study.

***By signing below, you represent that all of the above statements are true.***

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Chairman or Chief of Service

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date