

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