Children's of Alabama (COA) Researcher Project Provisioning Form

**** Important Instructions for researcher:**

Please return this completed form signed by your Sponsoring Physician/COA Medical Staff Supervisor (required) to Children's Information Technology Customer Support (IT CSD) at gethelp@childrensal.org.

- **You are responsible for contacting the IT CSD to ensure you have access required to start your research within the timeframe as indicated on this form.**

1. Researcher's Contact Information:

Name: | Address: | PhysID # (If known):

Business Email: | Business Phone:

2. Program Location: ☐UAB ☐Princeton/Baptist Health Systems ☐Trinity ☐St. Vincent's ☐Other:

3. Program Coordinator Contact Information:

Name: | Program Address:

Business Email: | Business Phone:

4. My Sponsoring Physician/COA Medical Staff Supervisor for project:

Name: | Department Address:

Business Email: | Business Phone:

5. Title of Research Project: **IRB number (if applicable):**

Researcher's Statement for Project Provisioning

- I agree to abide by the applicable laws regarding confidentiality and security, including HIPAA. https://www.hhs.gov/hipaa/for-professionals/index.html
- I understand that I will access records only to the extent and for the purpose of performing my assigned duties from my Sponsoring Physician/Supervisor on this research project.
- *I am responsible to encrypt any electronic COA Protected Health Information (on a laptop, mobile device) with encryption.*
- I will notify COA via gethelp@childrensal.org and/or HIPAA@ChildrensAL.org and my Sponsoring Physician immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my part or on the part of another person.

Printed Name / Signature | Date

**** REQUIRED - For completion by Sponsoring Physician/COA Medical Staff Supervisor:**

1. Dates of Access: The researcher must be granted research status access to COA protected health information **from:** **to** *(MM/DD/YY)*
2. Researcher Access to Read-Only iConnect? ☐**Yes** ☒**No** (mark one only)
3. Remote access: Do you require for the researcher to have remote access to COA protected health information? ☐**Yes** ■**No** **(**mark one only)

Signature of Sponsoring Physician/COA Medical Staff Supervisor:

Print Name / Signature | Date