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|  | Institutional Review Board**WAIVER OF INFORMED CONSENT**Return to the Office of Research Integrity1055 N. Curtis RoadBoise, ID 83706Phone: (208) 367-8897Phone: (208) 367-2233Kimberly.garst@saintalphonsus.org  |
| Confidential pursuant to Idaho Code |

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| Date of Application: Click here to enter a date. | IRB Number if known: Click here to enter text. |

Study Title:Click here to enter text.

*PRINCIPAL INVESTIGATOR (PI) INFORMATION: Please provide information about the person legally responsible for the conduct of the research. The Office of Medical Affairs must be assured that the investigator can personally oversee the conduct of the research and the protection of human subjects. {21 CFR 56.102(h)}*

Investigator Contact Information:

(*To add additional Team Members, simply highlight the below section, copy and paste)*

1.Name: Click here to enter text.

Mailing Address:Click here to enter text.

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| Phone:Click here to enter text. | Fax:Click here to enter text. | Email:Click here to enter text. |

2.Name:Click here to enter text.

Mailing Address:Click here to enter text.

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| Phone:Click here to enter text. | Fax:Click here to enter text. | Email:Click here to enter text. |

The following criteria must be satisfied to approve a waiver of Informed consent (authorization) under the Privacy Rule. The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:

1. Please provide an adequate plan to protect the identifiers from improper use and disclosure:

 Click here to enter text.

1. Please provide an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law:

Click here to enter text.

1. Please provide adequate assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted (the research could not practicably be conducted without the waiver or alteration; and the research could not practicably be conducted without access to and use of the protected health information).

Click here to enter text.

I agree that the information provided on this request form accurately reflects my research intentions. If my intentions change, I am required to resubmit this form. I agree to seek permission from the IRB before reusing this information for a different purpose or disclosing it to any other person or entity.

Click here to enter text.

**Principal Investigator (Typed/Printed Name)**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** Click here to enter a date.

***Principal Investigator's Signature Signature Date***

***Please visit the IRB website for all of your resources and forms at*** <http://www.saintalphonsus.org/forms-and-resources>