

# 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](mailto: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):
<input type="text"/>	<input type="text"/>	<input type="text"/>
Business Email:	Business Phone:	
<input type="text"/>	<input type="text"/>	

### 2. Program Location:

UAB  Princeton/Baptist Health Systems  
 Trinity  St. Vincent's  Other:

### 3. Program Coordinator Contact Information:

Name:	Program Address:
<input type="text"/>	<input type="text"/>
Business Email:	Business Phone:
<input type="text"/>	<input type="text"/>

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

Name:	Department Address:
<input type="text"/>	<input type="text"/>
Business Email:	Business Phone:
<input type="text"/>	<input type="text"/>

### 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](mailto:gethelp@childrensal.org) and/or [HIPAA@ChildrensAL.org](mailto: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.

<input type="text"/>	<input type="text"/>
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:

<input type="text"/>	<input type="text"/>
Print Name / Signature	Date