***North Texas Regional Institutional Review Board***

***Protocol Synopsis for Research Involving Chart Reviews***

**Instructions: To assist with timely and appropriate reviews of projects involving analysis of (more than one patient’s) medical records and/or charts, please fill out this document. Note that this protocol must list a full-time faculty member (not adjunct), staff member, or employee (not part-time) as the Principal Investigator. Please see below for instructions on submitting the project in IRBNet.**

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| **PROTOCOL INFORMATION** | **IRB Project # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(Office Use Only)** |
| ***Title of Project*:**       |  |
| ***Name of Principal Investigator:***      ***Department:***      ***Email:***       | ***Institution:***      ***Phone:***       |
| ***Name of Co-Investigator (s), students, medical residents, etc:***      |  |
| **Purpose of the Study-** *State the scientific objectives of the research (submit an additional page if needed).*  |
|        |
| **Background & Significance** **–** *Briefly describe the background leading to the present proposal (add page if needed).*  |
|       |
| **RESEARCH PLAN** (check all that apply) |
|   [ ]  Retrospective Chart Review (records already in existence will be studied)  [ ]  Prospective Chart Review (medical information/records not yet collected will be studied)  [ ]  BOTH Retrospective / Prospective Chart Review   |
| **RESEARCH PLAN (continued)** |
| The information in the chart/record to be used for research purposes, dates from (Month/Year)       through Month/Year)      **[Do NOT indicate *your* personal time frame for conducting this research record review]**  |
| Name of Facility (hospital, clinic, private practice, etc.) where the records will be/were obtained:       |
| How **many** individualpatients’ charts will be reviewed?       |
| How **often** will the researchers review the records (once per record, repeatedly, etc.)?       |
| **Who** will review the records/charts? *List anyone who will have access to the personal identifiers collected for research.*      |
| What is the source of medical information that will be reviewed / studied? (Check all that apply): [ ]  Entire Medical Record [ ]  Billing Records [ ]  Laboratory Results  [ ]  Pathology Records [ ]  Radiological Records [ ]  Interviews / Surveys / Questionnaires [ ]  Other (describe):       |
| What data items will be collected for research purposes? *Provide specific data fields****,*** *submit a data collection sheet, or* ***a brief narrative describing what information will be recorded for research purposes****.*      |
| **PROTECTED health information AND WAIVER OF INDIVIDUAL HiPAA AUTHORIZATION [45 CFR 164. 512 (i) (2) (i) - (v)]: *Medical Data that are connected to an identifiable person are considered protected health information (PHI) and subject to HIPAA regulations. In order to use such information (PHI) in research, the following section must be completed.***  |
| The use or disclosure of PHI must not involve more than minimal risk to the privacy of the individuals. Is the risk to subjects: [ ]  Minimal or [ ]  More than Minimal[Minimal risk is defined as the probability and magnitude of harm or discomfort anticipated in the research is not greater in and of themselves than ordinarily encountered in daily life or during the performance of routine physical or psychological examinations/ tests.] |
| Will personal identifiers be recorded or linked by a code (or “master list”) to the research data? Yes [ ]  No [ ]   If so, please list all of these identifiers:       How long will you keep the link (identifying code or “master list”) to the personal identifiers?      *State in terms which relate to the study timeline, such as: “after data entry is complete”, “until close of study”, etc. State N/A if no link will be kept. State “indefinitely” if the link will never be destroyed. If the link will be kept indefinitely, explain why the identifier must be retained, including whether it is needed for a health purpose, legal or institutional requirement, or another reason. Please note that the research dataset must be de-identified at the time of study closure (no identifying information should remain and a link or “master list” should be destroyed).*  |
| **PROTECTED health information AND WAIVER OF INDIVIDUAL HiPAA AUTHORIZATION (Cont.)****There must be an adequate plan to protect the identifiable health information from improper use or disclosure.** What security measures will be taken to protect the PHI? (e.g. identifiers are kept in a locked file cabinet only available to researchers; they are maintained in a password-protected database and only the researchers have access to the password.)       |
| How will the confidentiality of the research data be maintained?       |
| Do you plan to destroy the PHI that you have transferred/collected for research purposes after the completion of the research study? Yes [ ]  No [ ]  If so, when and how? If not, please give your rationale.        |
| **DATA SECURITY:**Will the PHI that you transfer or collect for research purposes, be transmitted to another institution/facility and/or person(s)? Yes [ ]  No [ ] If so, describe the precautionary measures you have in place to protect the confidentiality of the research PHI:       |
| Describe how the research data will be stored and protected. Note: Research data are the subset of data extracted from the subject’s clinical data (e.g., medical records) for research purposes.1. *For* paper-based information include the following information: where the data will be stored, who has access to the storage area, and how access will be monitored:
2. For electronic information: how electronic security will be maintained, what password protection and virus software are enabled, etc.:
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| Is the Principal Investigator the data steward? Yes [ ]  No [ ]  [*A data steward is the individual who creates, maintains and/or stores a file, which contains PHI and is responsible for that database*]*.*  If NO, who will be responsible?       |
| List all of the parties or persons that might have access to the study’s research data:       |
| **RISK/BENEFIT assessment** |
| **Potential Risks-** *Describe any* ***informational risks*** *(including breach of privacy, confidentiality risk, document access, risk of embarrassment, and other “risks” related to how sensitive information is stored, accessed, and managed):*      |
| **Potential Benefits-** *Describe any potential benefits to the subjects, society and/or science that may result from this research project.*      |
| **REQUEST FOR WAIVER OF INFORMED CONSENT [45 CFR 46. 116 (f) (3) (i – v)]:**Informed consent refers to a process whereby the researcher obtains the willingness of the participant to be included in research once all the necessary elements of consent (specified in federal regulations) have been disclosed. In order for the North Texas Regional IRB to grant this waiver for a chart review, all of the following conditions must be met. The **Principal Investigator** (PI) must certify each of these items by **initialing ALL of the statements.** |
| **THE PI MUST INITIAL ALL STATEMENTS!**\_\_\_\_\_\_ (initial) The research involves no more than minimal risk to the participants.\_\_\_\_\_\_ (initial) The research could not practicably be carried out without the waiver. “Practicably” means there is no practical way to either implement a consent document or disclose all the elements of consent without jeopardizing the validity of the study.\_\_\_\_\_\_ (initial) If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format.\_\_\_\_\_\_ (initial) The waiver will not adversely affect the rights and welfare of the participants.\_\_\_\_\_\_ (initial) Whenever appropriate, the participant or legally authorized representative will be provided with additional pertinent information after participation. |
| **INVESTIGATOR’S CERTIFICATION / ASSURANCE**I certify that the information provided in this request for protocol review is complete and correct. I understand that I have the ultimate responsibility for protecting the confidential information of individuals and ensuring the privacy of their protected health information. I agree that subjects will not be identified by name in any presentation or publication related to this research project. Further, I attest that I, and any person listed as key personnel on this protocol has legal and institutional authorization to access and examine the medical records to be studied in this project, and take full responsibility for their access and use of these records. Finally, my signature below is my representation that I and any individual listed as research personnel on this protocol have ***no* financial or other conflict of interest** that could adversely affect a subject or their data in this study. I acknowledge that I am required to notify the North Texas Regional IRB within 10 business days if a change in my, or any individual listed as key personnel on the protocol, disclosure status occurs. **Signature of Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**SUBMISSION GUIDANCE**

**(Do NOT submit this guidance page!)**

* **Please submit all documents in IRBNet (**[**www.irbnet.org**](http://www.irbnet.org)**). Register as a New User (if you haven’t done so already), and select “Create New Project” in the left-hand navigation bar.**
* Please note the following:
	+ **THE PRINCIPAL INVESTIGATOR MUST HAVE FULL ACCESS TO THE IRBNET PROTOCOL PACKAGE IN ORDER FOR IT TO BE REVIEWED BY THE IRB.**
	+ Please be sure to use a very descriptive file name for each document submitted as a pdf or word.doc file.  Example: “MMSE scale” is much better than “Scale 1”…. “Recruiting flyer” is better than “Ad 1”, and so forth.
	+ Refer to the “Read Me First” document located in IRBNet under “Forms and Templates” for additional guidance.
* In addition to the application, please upload the following documents in IRBNet:
	+ Certificate of Human Subjects Training (such as CITI) for all study personnel.
	+ Signed letter of permission from the institution/facility (e.g., hospital, clinic, physician) authorizing access and review of the records. NOTE: If Principal Investigator has authorized access to patient records, this letter need not be provided.
	+ Signed conflict of interest forms (COI) for all persons listed as key personnel on this protocol. (Note: COI forms are NOT required for Exempt category projects.)