Reset Form

AGREEMENT FOR RELEASE OF DATA CONTAINING CONFIDENTIAL INFORMATION

State Form 52104 (R3 / 8-23)

Indiana Department of Health

Pursuant to Indiana Department of Health Policy, Indiana Code and/or Indiana Administrative Code, you are required to provide the following information and make the following covenants. Failure to complete this form and maintain these covenants may cause your request to be denied. Upon completion, this form will become a PUBLIC RECORD.

Information Requested (*List Title*)	
Purpose of Request	
Name of Requestor	Job Title
Street Address	City, State, ZIP
Telephone and Fax Numbers	E-mail Address

As a condition of receiving data, I/we agree that:

1. I/We shall use this information solely for the purpose of the approved research study or activity stated above. *(Unauthorized use may cause the Indiana Department of Health to deny any future request for data.)*

2. The **information requested is confidential** pursuant to IC 5-14-3-4, IC 16-19-10-8, IC 16-37-1-10, IC 16-38-2-5, IC 16-38-4-11, 410 IAC 3-3-7, IC 16-38-5-3, IC 16-38-6-6, IC 16-39-5-3, IC 16-41-8 or other state or federal law.

   I/We shall not publish or release the names of individuals or any facts tending to lead to the identification of individuals named in the data. Specifically, I/we shall neither release publicly nor publish data or aggregated data in which the cell sizes are less than five (5).

3. I/We guarantee that the **confidentiality of the information** provided by these data will be maintained, and that no information provided in these data will be used for the purpose of follow-up contact with the survivors, family, or physicians unless expressly authorized by the Indiana Department of Health.

4. I/We shall provide the Indiana Department of Health with a written plan of action for final disposition of these data upon completion of the specified research activity.

5. I/We shall pay actual costs *(including staff time and materials)* of copying this information for my/our use.

6. The Indiana Department of Health (IDOH) may cancel this Agreement if IDOH believes that its use does not serve the public interest. IDOH will, however, give written notice stating the reason(s). Upon receiving this notice, I/we shall cease using the data and shall destroy any copy of the data I/we hold.

7. I/We may cancel this Agreement by notifying the Indiana Department of Health in writing and by destroying any copy of the data I/we have.

8. I/We will submit a report every six (6) months including the following information: the status of the project, expected termination date, changes in study protocol, any changes to persons with access to the requested data, and final disposition of the data.

9. I/We grant the Indiana Department of Health *(with prior notice)* the right to visit my/our facility for the purpose of ensuring that the conditions stated above are being met.

10. I/We have attached a list of all persons who will have access to the data. The persons on this list are aware of the conditions of this Agreement and have signed a **statement of confidentiality** which is in my/our possession. This list will be updated, as needed, and resubmitted at the time of the six (6) month report required above. I/We affirm that no portion of the data covered by this Agreement will be released or disclosed to any other individual or entity for any purpose.

11. This agreement is effective when the request is approved by the Data Release Committee of the Indiana Department of Health.

12. Failure to comply with these conditions constitutes a breach of contract and could result in civil action by data subject(s) per IC 4-1-6-8.6.

Signature of Requestor	Date (*month, day, year*)

(CONTINUED ON OTHER SIDE)

Persons with access to the requested data:

Name	Position/Affiliation	Location

(***Attach additional sheets, if necessary.***)

STATE AGENCY USE

Request	Authorizing Official
☐ Approved ☐ Denied	Date (*month, day, year*)