UCSF
UCSF MEDICAL CENTER CANCER REGISTRY

(Cancer Registry Voice: 353-9700)

DATA REQUEST FORM (Cancer Registry Fax: 353-9716)

Please complete this form for all cancer data requests.

Your name:_____

Provider # or job title:_____

Department:_____

Room/Box #:_____

Phone/Beeper_____

Cost Center_____ **DBS # Account/Fund**_____

1. **Purpose of request: (check one)**

___Research ___ Publication ___ Patient Care ___Education

___Administrative ___Billing/Payment _____Other

2. **If the purpose of this request is for Research or Publication, complete the following items and sign this data request form:**

   A) Attach a copy of each of the following:

   - CHR-approved protocol
   - Consent documents (if any)
   - CHR Approval Letter or CHR Certification of Exempt Status

   B) What is your CHR approval number? _____

Note: According to 45 Code of Federal Regulations46.102 research is defined as "…*a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge."*

DATA REQUEST FORM CONT:

3. **If the purpose of your request is for Patient Care, Education, Administrative, Billing/Payment, or Other (as checked in item #1), complete the following items and sign this data request form:**

   A) Give a brief description of your project in the space below:

   B) Indicate all identifiers (PHI) that may be included in the study research records:

Check all that apply:		
☐ Names	☐ Social Security Numbers	☐ Device identifiers
☐ Dates	☐ Medical record num.	☐ Web URLs
☐ Postal address	☐ Health plan numbers	☐ IP address numbers
☐ Phone numbers	☐ Account numbers	☐ Biometric identifiers
☐ Fax numbers	☐ License/Certificate numbers	☐ Photos/comparable images
☐ Email address	☐ Vehicle ID numbers	☐ Any other unique identifier

   C) Please justify the need to use PHI in the space below:

   D) Will you be contacting patients? ____No ____Yes. If yes, please justify the need.

4. **In signing below, I understand that patient data is confidential and may not be revealed to unauthorized persons, agencies, etc. without the written consent of the patient.**

   Signature_____ **Date**_____