Hawaii Pacific Health
55 Merchant Street • Honolulu, Hawaii 96813 • hawaiipacifichealth.org

Registry Information Form

PRIMARY CONTACT INFORMATION: Please provide information about the person responsible for the maintenance of the registry. HPH must be assured that the person responsible can personally oversee the registry and the protection of the registry data.

1.	Primary Contact Name:		
2.	Primary Contact Company Name:		
3.	Primary Contact Mailing Address: (street, city, state/province, zip, country)		
4.	Primary Contact Phone: ( )	Primary Contact Fax: ( )	Primary Contact E-mail:
5.	How would the Primary Contact prefer to be contacted? (check one) ☐ Fax ☐ E-mail ☐ Regular Mail		

Registry Information

1. Describe the purpose of the registry and how the information will be used:

2. Specify which, if any, of the following identifiers will be associated with the health information you propose to **collect and use** for the registry.

	Names		Telephone Numbers
	Address		E-mail Addresses
	Fax Numbers		Medical Record Numbers
	Social Security Numbers		Account Numbers
	Health Plan Beneficiary Number		Vehicle Identifiers and Serial Numbers
	Certificate/License Numbers		Web Universal Resource Locators (URL)
	Device Identifiers and Serial Numbers		Biometric Identifiers (finger and voice prints)
	Internet Protocol (IP) Address Numbers		
	Any Geographic Subdivisions Smaller Than a State (specify which of the following identifiers you will use: county, city, parish, or zip code):		Any Elements of Dates (specify which of the following identifiers you will use: birth date, admission date, discharge date, date of death, age over 89 and all elements of dates indicative of such age [including year]):
	Full face photographic images and comparable images:		Any other unique identifying number, characteristic, or code (please specify):

3. List the specific **health information** that you propose to collect and use in this registry. State specifically whether sensitive information (e.g., illegal drug use, sexual practices, HIV status) will be collected. A copy of the data collection sheet and/or survey or interview questions also should be submitted.

HPH Registry Info Form 2012.12.31

Registry Information Form

4.	What is the source of the Protected Health Information ("PHI")? List all sources from which you plan to obtain PHI for the registry *(e.g. Facility or clinic paper records, a departmental database, your own database)*		
5.	Who will have access to, receive and/or use the information?		
6.	Are the persons who will have access to the information required to sign confidentiality statements?	Yes ☐	No ☐
7.	What identifiers are included on the information you plan to disclose?		
8.	List, if any, the individuals or groups outside of HPH to whom you will disclose the PHI (*e.g., collaborators from other institutions*). If PHI will NOT be released outside of HPH in this study, please make a statement to that effect.		
9.	In what form will the PHI be maintained? ☐ Paper ☐ Electronic ☐ Both		
10.	If the information is in paper format, describe the precautions you have to protect the PHI from improper use and disclosure:		
11.	If data is stored electronically (PC, laptop, CD, DVD, thumb drive, portable storage device, etc.), what safeguards[1] are in place to prevent access to the electronic files? ☐ Password protected – describe password complexity: ______ ☐ Encryption – describe encryption protocol used: ______ ☐ Other (please specify): ______		
12.	How will the electronic data be stored? ☐ PC ☐ DVD ☐ HPH server ☐ Laptop ☐ Thumb drive ☐ Other server (please specify): _____ ☐ CD ☐ Portable storage device ☐ Other (please specify): _____		
13.	Will electronic data be transmitted outside of your site?	Yes ☐	No ☐
14.	If electronic data is/will be transmitted, describe safeguards used to secure[1] data during transmission.		

By signing this statement, I am providing written assurance that only information essential to the purpose of this registry will be collected. Access to the information will be limited to the greatest extent possible and I understand any identifiable data placed on portable electronic media or other devices must be encrypted. Protected health information will not be re-used or disclosed to any other person or entity not listed on this form.

You may type your name on this form and send it electronically. Your typed name on this form will constitute your signature and agreement with the aforementioned statement.

____ ____________________

Signature of Primary Contact Date

---

[1] Security Requirements: Identifiable patient information must be rendered unusable, unreadable or indecipherable to unauthorized persons. See NIST Special Publications 800-111, 800-52, and 800-77 for recommendations