

## Disclosure Statement

I do hereby agree that the data I receive from the Trauma Program Office is to be held in strict confidence in keeping with the confidentiality rules and regulations that are governed by the University of Kentucky Hospital HIPPA policies and procedures. It is my understanding that any patient information that I receive in this report is to be used solely for the purpose of research and will not be disclosed to the public in any way other than that in which it is intended

- *I agree to seek the approval of the Internal Review board prior to beginning extensive research.*
- *I agree to seek the approval of the Internal Review Board prior to publishing any information received from the Trauma Program Office.*
- *I agree not to disclose patient identifiers i.e. name, MRN, SS#, address or any other such variables that my disclose a patients identity.*
- *I agree to seek the approval from the Trauma Program Office prior to presenting or publishing my research.*
- *I agree to give proper reverence to the University of Kentucky Trauma Program for all work that utilizes provided data from the trauma registry.*
- *I agree to submit a copy of my final project to the Trauma Program Office upon completion*

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

TPO Official: \_\_\_\_\_

Date: \_\_\_\_\_