ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE

Certification of Project Completion & Destruction or Retention of Data

Project Title:

Date: Phone Number:

Organization:

Mailing Address:

City: State: ZIP Code:

Person responsible for privacy and/or security:

Email: Phone Number:

Instructions: Data must be destroyed so that it cannot be recovered from electronic storage media in accordance with the methods established by the "Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals," as established by the U.S. Department of Health and Human Services (HHS).

I/we hereby certify that the project described in the Data Release Request is complete as of this date: ,20

Complete the appropriate section below:

☐ I/we certify that we have **destroyed** all data received from ACHI in connection with this project, in all media that were used during the research project. This includes but is not limited to data maintained on hard drive(s), diskettes, CDs, etc.

☐ I/we certify that we are **retaining** the data received in connection with the aforementioned project, pursuant to the following justification:

☐ New data use agreement (as applicable for data retention):

☐ Certification of Data Destruction	☐ Request to Retain Data
Date the data was destroyed:	Date until data will be retained:

Signature of Duly Authorized Representative:

Printed Name:

Title: