



### Data Utilization Agreement

The Alaska Section of Women's, Children's, and Family Health (WCFH) places the following conditions on the acceptance and utilization of \_\_\_\_\_ (*dataset/program name*) data collected and maintained by WCFH:

\_\_\_\_\_ (*primary applicant name*) located in \_\_\_\_\_ will have access to the data for research and analysis as defined on the attached data request. If individuals with access to the data change due to staffing transitions or changes in employment status, WCFH will be notified and new contact information will be provided. Other persons may have access to the data only for technical support and with prior approval from WCFH.

*Initial each item (primary applicant only).*

\_\_\_\_\_ "Ownership" of the data set remains with WCFH. Under HIPAA, the individual or patient is the "owner" of his/her data; all others have limited rights of use. When the proposed analyses are completed, all copies of these data will be destroyed (confirmed in writing), or returned to WCFH. If data must be maintained, this must be explicitly stated on the Data Request.

\_\_\_\_\_ Access to the data set will be protected by a security system that requires the user to provide at least one password.

\_\_\_\_\_ Release of non-aggregated or semi-aggregated data to any other individual or agency without the express permission of the WCFH Program Manager is prohibited; only aggregate/summary data (meeting the State of Alaska HIPAA criteria for data release) appropriate for public reporting shall be shared or published.

\_\_\_\_\_ The recipient will commit to protecting the identity of individuals whose information is in the dataset. (Although names may not be provided, in some communities, the dates, age, sex, race and place may be sufficient to identify an individual.) No use will be made of the identity of a person discovered inadvertently.

\_\_\_\_\_ All prevailing laws and regulations relating to the protection of individually-identifiable information will be followed (this includes HIPAA privacy regulations).

\_\_\_\_\_ The recipient and any associate with access to the data set for analysis purposes acceptable as part of this data request will submit to the WCFH Program Manager a signed Data Utilization Agreement (DUA). If it is not feasible for all members of the research team to sign, the Primary Applicant listed on the DUA is responsible for ensuring all members of the team respect and follow the conditions as outlined in the

Agreement, and they must initial a statement acknowledging they accept this responsibility. If a need exists to utilize the data past the end date indicated on the Data Request, a new Data Utilization Agreement must be signed.

\_\_\_\_ The data may be used only for public health research, public health program evaluation, or public health planning purposes, as described in the attached data request form.

\_\_\_\_ The recipient will allow WCFH at least two weeks to review conclusions based upon data prior to presentation or submission to a journal or report publication. This is to ensure correct interpretation of the data. If disagreement exists, the recipient will allow WCFH the opportunity to include comment within the published document. Acknowledgement is to be given to WCFH as the source of data in any oral or written presentations of the results. WCFH will be notified upon final publication of an article or report and provided with citation information.

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I have read and agree to the above conditions of use for data from the Alaska Section of Women’s, Children’s, and Family Health. By signing, I also agree to observe HIPAA privacy and confidentiality rules and regulations.

**Primary Applicant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Affiliation:** \_\_\_\_\_

\*\*Primary Applicant is signing on behalf of all co-investigators and acknowledges responsibility for ensuring co-investigators will follow the above conditions for use of data and will observe HIPAA privacy and confidentiality rules and regulations. If applicable, Primary Applicant must initial here: \_\_\_\_\_

**Additional individuals with access to the data** (add lines for additional people as needed)

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Please fax completed form to (907) 269-3493 or email a scan of completed form to [mch-epi@alaska.gov](mailto:mch-epi@alaska.gov)



**Data Request**  
**Section of Women's, Children's, and Family Health**

**Project Title:** \_\_\_\_\_

**Short Description and Purpose of Project:**

Include anticipated end date of project.

- Please attach a full study protocol following the MCH Epidemiology Data Sharing Protocol Outline, if deemed necessary by the WCFH Program Manager.

**Description of Data Requested:**

Please state specific years, variables of interest, etc.

**Primary applicant (person receiving data transfer):** \_\_\_\_\_

**Agency** \_\_\_\_\_

**Address** \_\_\_\_\_  
\_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

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**WCFH USE ONLY**

**Request approved** \_\_\_\_\_ \*Conditions for approval attached (if applicable).

A signed Data Utilization Agreement must be received prior to sharing data.

**Request denied** \_\_\_\_\_ \*Reasons for denial attached.

**Name of reviewer:** \_\_\_\_\_ **Date:** \_\_\_\_\_