SHAHEED MOHTARMA BENAZIR BHUTTO
INSTITUTE OF TRAUMA
Department of Research & Development

PATIENT's MEDICAL RECORD REQUEST FORM

(Only for Research)

To be filled by the Researcher

Researcher Name		**Designation**	
Department Name		**Telephone /Ext #**	
SMBBIT Employee # / CNIC # for outsiders		**Email address**	
Type of review	☐ Research ☐ Audit ☐ Presentation ☐ Others Specify_____ ☐ Student's Project		
Description of study/project:			
The concerned department/s in whose field/domain the study/project is to be conducted:			
Record Review Period: **Date from_____to _____**			
Ethical Review Committee (ERC) Approval: ☐ Yes ☐ No ☐ Exemption (Please attach the ERC approval /Exemption letter)			
CONFIDENTIALITY STATEMENT: I understand that the patient's medical records are confidential. I agreed that any hospital-specific information for clinical care, treatment, processes, medications, or systems might not be released without prior approvalof the SMBB Institute of Trauma Research Board. I am reassuring that the medical record files/electronic records will be collected in the presence of the record keeper. I agree to obey the Institutional policies.			
Signature of the Researcher		**Date**	

To be filled by the Researcher's Supervisor/HOD

HOD /Supervisor Name		**Department Name**	
SMBBIT Employee # / CNIC #(for outsiders)		**Telephone /Ext #**	
HOD/ Supervisor Signature:			

For Office use

Approved by			
Executive Director (ED)	Name	Signature with Date	
Chair of Ethics Review Committee (ERC)	Name	Signature with Date	
Manager Research and Development	Name	Signature with Date	
In charge of the Medical Record Room	Name	Signature with Date	