# SHAHEED MOHTARMA BENAZIR BHUTTO
## INSTITUTE OF TRAUMA
Department of Research Development (DRD)

**PATIENT's MEDICAL RECORDREQUEST FORM (for Research only)**
(To be filled by the Researcher)

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|---|---|---|---|
| **Researcher Name** | | **Designation** | |
| **Department Name** | | **Telephone /Ext #** | |
| **SMBBIT Employee # / CNIC # for outsiders** | | **Email address** | |
| Type of review | ☐ Research ☐ Audit<br>☐ Presentation ☐ Others Specify_____<br>☐ Student's Project | | |
| **Description of study/project:** | | | |
| **The concerned department/s in whose filed /domain the study/project is to be conducted:** | | | |
| **Record Review Period:**<br>**Date from_____to _____** | | | |
| **Ethical Review Committee (ERC) Approval:** ☐ Yes ☐ No ☐ Exemption<br>(Please attach the ERC approval /Exemption letter) | | | |
| **CONFIDENTIALITY STATEMENT:**<br>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 record will be collected in presence of record keeper. I agree to obey the Institutional Polices. | | | |
| **Signature of the Researcher** | | **Date** | |

## To be filled by the Researcher's Supervisor/HOD

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

## For Office use

| **Approved by** | | | |
|---|---|---|---|
| Incharge of Medical Record Room | Name | Signature with Date | |
| Manager Research and Development | Name | Signature with Date | |
| Chair of Ethics Review Committee | Name | Signature with Date | |
| Executive Director | Name | Signature with Date | |