SHAHEED MOHTARMA BENAZIR BHUTTO
INSTITUTE OF TRAUMA

PATIENT's MEDICAL RECORD REQUEST FORM

(To be filled by the researcher for the patient's medical records request)

Department of Research Development (DRD)

Name of Researcher		**Designation**	
Department		**Telephone /Ext #**	
SMBBIT Employee # / CNIC #(outsiders)		**Email address**	
Type of review	☐ Research ☐ Audit ☐ Presentation ☐ Others Specify_____ ☐ 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: **Date from_____to _____**			
CONFIDENTIALITY STATEMENT: I understand that the patient's medical records are confidential. May release no information regarding a patient without a signed authorization from the patient and SMBB Institute of Trauma. I understand that any hospital-specific information for clinical care, treatment, processes, medications, or systems may not be released without prior approval of the SMBB Institute of Trauma Research Board. In my review of these records, I agree to obey these requirements.			
Signature of the Researcher		Date	

To be filled by the Researcher's Supervisor/HOD

Department Head/Chairperson Name		**Designation**	
Department		**Telephone /Ext #**	
SMBBIT Employee # / CNIC #(outsiders)			
Ethical Review Committee (ERC) Approval: ☐ Yes ☐ No ☐ Exemption (please attach the ERC approval /Exemption letter)			
Department Head/Chairperson Signature:			

For the Department of Research and Development Office use

Approved by			
Manager Research and Development	Name	Signature &Date	
Chair of Ethics Review Committee(ERC)	Name	Signature &Date	
Chief Operating Officer (COO)	Name	Signature &Date	