



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

IRB PATIENT'S MEDICAL RECORD REQUEST FORM FOR RESEARCH DATA COLLECTION

(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	<input type="checkbox"/> Research <input type="checkbox"/> Presentation <input type="checkbox"/> Student's Project	<input type="checkbox"/> Audit <input type="checkbox"/> Others Specify _____	
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 _____			
Institutional Review Board (IRB) Approval: (Please attach the IRB approval /Exemption letter) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exemption			
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 approval of 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 Institutional Review Board (IRB)	Name	Signature with Date	
Manager Research and Development	Name	Signature with Date	
In charge of the Medical Record Room	Name	Signature with Date	