SHAHEED MOHTARMA BENAZIR BHUTTO
INSTITUTE OF TRAUMA

MEDICAL RECORD REQUEST FORM

(To be filled by the reviewer for record request)

Name of the Reviewer/s		**Designation**	
Department		**Telephone /Ext #**	
SMBBIT Employee # / CNIC #(outsiders)		**Email address**	
Type of review	☐ Research ☐ Presentation ☐ Student's Project	☐ Audit ☐ Others Specify________________	
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** ________________	
Signature of the Reviewer			

To be filled by the reviewer's supervisor

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

CONFIDENTIALITY STATEMENT:

I understand that the patient's medical records are confidential. No information regarding a patient may be released without a signed authorization from patient and SMBBTC. I understand that any hospital specific information for clinical care, treatment, processes, medications or system may not be released without prior approval of the SMBBTC Research Board. In my review of these records, I agree to obey with these requirements.

Signature of the Reviewer		**Date**	

For Office use

Approved by			
Research Officer SMBBIT	Name	Signature &Date	
Concerned department Head	Name	Signature &Date	
Chair Ethical Review Committee(ERC)SMBBIT	Name	Signature &Date	
Chief Operating Officer (COO)SMBBIT	Name	Signature &Date	