HEALTH INFORMATION MANAGEMENT REQUEST CENTER
APPLICATION TO REQUEST MEDICAL RECORDS

INSTRUCTIONS: Please complete the information below. If your request for access to medical records is approved by your Department chairman/director, submit this form to Lucy Moreno, Department of Health Information Management (Rt. 0782) for processing.

NAME OF REQUESTOR:_____ ROOM NUMBER:_____

JOB TITLE:_____ ROUTE:_____

DEPARTMENT:_____ EXT:_____

REASON(S) FOR REQUEST:_____ BEEPER #:_____

_____

I understand and accept the legal responsibility as a record requestor to use these records in the normal course of business and only for purposes where I professionally and legally have the right to review such records. I will make every effort to fully protect the **CONFIDENTIALITY** of the records.

Further, I understand and agree to abide by the UTMB Medical Record Access Policy. This includes not removing medical records from hospital premises, not sequestering medical records in office, desks, or briefcases, and returning medical records to the Health Information Management Department for patient care availability by 5 P.M. each day. Failure to comply with any part of the UTMB Medical Record Access Policy may result in termination of privileges to request and obtain medical records.

Signature of Requestor: _____

I, as Department Director/Chairman hereby certify that the above requestor, Mr./Ms./Dr. _____

_____ has an appropriate and valid reason to have access to medical records.

Signature:_____ Date:_____

Print Name:_____

Title:_____ Dept:_____

HEALTH INFORMATION MANAGEMENT DEPARTMENT USE ONLY

_____ Approval
Date _____

_____
Medical Record Administrator
Record Management Division
Department of Health Information Management

_____ Disapproval
Date _____

Reason for Disapproval:_____

_____

_____ Access Code

J:Share/Forms/med-req2
Revised 8/05