Medical Record Research Request from Methodist Healthcare

Please complete the following request for medical record research from any Methodist Healthcare facility. Following review by Methodist Healthcare IRB Administration and Health Information Management (HIM) administration, you will be notified of the status of your request and how to proceed. All areas must be completed and all required documents submitted for your request to be considered. Send your completed form and documents to:

Methodist Healthcare IRB Administration
Wilson Hall
251 S. Claybrook, Suite #222
Memphis, TN 38104 telephone: 901-516-2323 fax: 901-516-2456

1. Check one reason for request:  
   - [ ] Research study
   - [ ] Case report for possible publication
   - [ ] General investigation for internal use–not for publication
   - [ ] General investigation for internal use—possible publication
   - [ ] Adjudication of an adverse event in a research study
   - [ ] Diagnostic test data related to a research study
   - [ ] Other: _________________________________________

2. Check from which Methodist Healthcare (MH) facility you are requesting records:
   - [ ] All adult hospitals
   - [ ] Germantown Hospital
   - [ ] North Hospital
   - [ ] Le Bonheur Children’s Medical Center
   - [ ] South Hospital
   - [ ] University Hospital
   - [ ] Affiliated Services (Home Health, Hospice, Infusion, HME, Minor Meds, Urgent Care, and Wound, Sleep, Diagnostic and Surgery Centers)
   - [ ] Methodist Extended Care Hospital (MECH)
   - [ ] Fayette Hospital

3. Check from which source you are requesting records:
   - [ ] Paper records from HIM department
   - [ ] Microfilm records from HIM department
   - [ ] Electronic/Cerner records
   - [ ] Paper or microfilm records from Affiliated Services
   - [ ] Records from an MH registry or database
     Specify: ____________________________

4. Brief description of research study/project/investigation.
5. Does the request involve collection of personal health information (PHI)?
   [ ] No
   [x] Yes
   List PHI elements to be collected: _______________________________________
   or attach a copy of data collection tool

6. Is this an IRB approved research study?
   [ ] No
   [x] Yes  Identify the approving IRB: _______________________________________
        IRB address: ___________________________________
        Date of initial IRB approval: _____________
        Approval date expiration:   _____________
        Indicate type of approval granted by IRB:  
                                           [ ] Full approval
                                           [ ] Expeditied approval
                                           [ ] Exemption certification

       Must attach copy of IRB approval letter to this request.

7. Is a separate informed consent required by the IRB for the collection of data?
   [ ] No
   [x] Yes If yes, must attach a copy of the IRB approved informed consent form.

8. Specify what information is being requested.
   Check all that apply and be specific as to the data desired. May attach data collection tool.
   [ ] a. complete medical record(s) regarding (specify patient name(s), DRG code, etc.): 
      Number of records requested: _____________
      Date of record(s) requested: __/__/__ to __/__/__
   [ ] b. partial medical record(s) regarding (specify patient name(s), DRG code, etc.):
      Number of record(s) requested: _____________
      Date of record(s) requested: __/__/__ to __/__/__
   [ ] c. patient list regarding (specify patient name(s), DRG code, etc.):
      Date of record(s) requested: __/__/__ to __/__/__
   [ ] d. data from medical records regarding:
      Date of record(s) requested: __/__/__ to __/__/__
9. What changes/outcomes/results are expected to occur as a result of the proposed record request?

10. List all individuals who will be obtaining or reviewing the records. **Print or type names.**

<table>
<thead>
<tr>
<th>Name: ______________________________</th>
<th>Contact number: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH credentials: □ Yes  □ No</td>
<td></td>
</tr>
<tr>
<td>Name: ______________________________</td>
<td>Contact number: __________________</td>
</tr>
<tr>
<td>MH credentials: □ Yes  □ No</td>
<td></td>
</tr>
<tr>
<td>Name: ______________________________</td>
<td>Contact number: __________________</td>
</tr>
<tr>
<td>MH credentials: □ Yes  □ No</td>
<td></td>
</tr>
</tbody>
</table>

11. Name, address and contact information for individual requesting record(s). **Print or type.**

Name: __________________________________
Address: __________________________________
                                            ______________________________
MH credentials: □ Yes  □ No
Telephone: __________________    Pager/Beeper: __________________
Fax: _____________   Email: _____________________________________________

12. Name, address and contact information for **principal investigator** if this is a research study.

Name: __________________________________
Address: __________________________________
                                            ______________________________
MH credentials: □ Yes  □ No
Telephone: __________________    Pager/Beeper: __________________
Fax: _____________   Email: _____________________________________________
By signing this request you are agreeing to abide by all MH compliance and ethical standards.

__________________________________                               ________________  
Printed name of person making request                                                       Date  

___________________________________  
Signature of person making request

___________________________________  
Signature of principal investigator

Printed name of principal investigator  

Date

Stipulations:
1) Once approval is obtained the request must be submitted to the appropriate HIM department within 7 working days after approval or the request is forfeited unless approved by the HIM Director.
2) MHIRB approval does not ensure that the HIM department will provide the records. If the request exceeds the departmental capabilities at the time of the request the request may be delayed or denied by the HIM Director.
3) The HIM department will provide access to the first 100 records at no cost. If copies are requested there will be a $2.00 charger per record and a $3.00 charge for microfilm record for each additional record over 100. Payment is required at the time of review and made payable to the HIM Department – [specific facility].
4) Affiliated Services will supply records at a cost and rate determined by Affiliated Administration established at the time of the request.

Please do not write below this line. For use by MHIRB and HIM Administration

_____  Request is **APPROVED** as submitted.

__________________________________                               ________________  
MHIRB Administration                                                       Date

__________________________________                               ________________  
HIM Director/Affiliated Director                                               Date

The HIM department will provide the records at the rate of _________ per week.  
All record review must be completed within _______________ days of approval.

Take this approval form and copies of signed informed consents for ALL records requested (if an informed consent is required by the IRB) to the appropriate
facility HIM Department to obtain the records.

_____ Request is **approved but DELAYED**

_______________________________________                _________________  
MHIRB Administration                                                        Date

_______________________________________                _________________  
HIM Director/Affiliated Director                                                Date

**Contact HIM Director at _____________ to arrange a date to obtain records.**

The HIM department will provide the records at the rate of __________ per week.  
All record review must be completed within _______________ days of approval.

This approval form and copies of signed informed consents (if IRB mandated) are  
required to obtain the records once a date is arranged and approved by HIM.

_____ Request is **DENIED** for the following reason(s):

☐ IRB approval required before consideration. Resubmit with all required information.  
☐ Required information missing: _____________________________  
                                 Resubmit with all required information.  
☐ Request exceeds capability of HIM to provide records.  
☐ Request not in keeping with MH policies or values or mission.

_______________________________________                _________________  
MHIRB Administration                                                        Date

_______________________________________                _________________  
HIM Director/Affiliated Director                                                Date

Date sent to person making request: _________________       via ☐ Fax    ☐ Mail
According to the Tennessee law, medical records do not constitute public records and therefore the information contained within the medical records is considered confidential. The Tennessee Code Ann. § 63-2-101(b)(1) and (2) allow disclosure of patient-identifying information for:

1) statutory required reporting to health or government authorities;
2) the third party payors such as insurance companies for the purpose of utilization review, case management, peer reviews or other administrative function; and
3) pursuant to a subpoena issued by a court of competent jurisdiction

The Patient’s Privacy Act grants patients a statutory right to privacy for care received at a hospital or clinic [Tenn. Code Ann. § 68-11-1502] and prohibits disclosure of name, address and other identifying information of a patient.

All other requests required approval via the process outlined above.