

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
☐ Yes

List PHI elements to be collected: _____
or attach a copy of data collection tool

6. Is this an IRB approved research study?

☐ No
☐ Yes

Identify the approving IRB: _____
 IRB address: _____
 Date of initial IRB approval: _____
 Approval date expiration: _____
 Indicate type of approval granted by IRB: ☐ Full approval
☐ Expedited 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
☐ 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.**

Name: _____ Contact number: _____
MH credentials: ☐ Yes ☐ No

Name: _____ Contact number: _____
MH credentials: ☐ Yes ☐ No

Name: _____ Contact number: _____
MH credentials: ☐ Yes ☐ No

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	

_____ Printed name of principal investigator	_____ Date
_____ Signature of principal investigator	

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 <u>APPROVED</u> as submitted.				
<table style="width: 100%;"> <tr> <td style="width: 60%;"> _____ MHIRB Administration </td> <td style="width: 40%;"> _____ Date </td> </tr> <tr> <td> _____ HIM Director/Affiliated Director </td> <td> _____ Date </td> </tr> </table>	_____ MHIRB Administration	_____ Date	_____ HIM Director/Affiliated Director	_____ Date
_____ 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.