

**SUBSIDIARY MEDICAL RECORDS (SMR) DECLARATION**

Date: \_\_\_\_\_

1. Name of person completing questionnaire: \_\_\_\_\_

Title: \_\_\_\_\_ Ext. \_\_\_\_\_

Dept.: \_\_\_\_\_

2. Who has been designated as your Record Custodian (i.e., This person will be the responsible individual for transitioning your records to an HIM Satellite Operation or to Source Data and will be the liaison with the Health Information Committee):

\_\_\_\_\_

3. SMRs contain information on what type of patient population (i.e., psychiatry notes)

\_\_\_\_\_

\_\_\_\_\_

4. Why was it necessary to maintain medical records separate from the Unit Medical Records?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. What is the exact or approximate number of existing records? \_\_\_\_\_

6. How many additional subsidiary medical records are created and/or maintained annually?

\_\_\_\_\_

7. Where is the physical location of subsidiary medical records? \_\_\_\_\_

\_\_\_\_\_

8. What days of the week and hours of the day are records available to other appropriate UTMB requestors?

\_\_\_\_\_

\_\_\_\_\_

9. In accordance with new hospital policies and new federal HIPAA regulations, I am requesting the following (select one option):

\_\_\_\_\_ A. I request that we be able to transition our SMR to an HIM Satellite Operation

\_\_\_\_\_ B. I will transition our SMR to the HIM Department

---

\_\_\_\_\_  
Signature of Clinical Chairman or  
Department Director

\_\_\_\_\_  
Date

