

**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 _____	_____
_____	Disapproval Date _____	Reason for Disapproval: _____
_____	Access Code	_____