

**Request No:**

*(HIS use only)*

## Health Information Services (HIS)

## Multiple Medical Record Request Form

 **HIS ext: 62644 Fax: 62424 Email: hisclinialrequests@alfred.org.au**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Requested By (full name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext / Mobile No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pager No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Records Required: ASAP or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Request:**

 Clinical Trial Research Internal Quality Audit Other: ……………………

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cost:**

$23 per volume

Complete the following:

**Invoice Details:**

Name of person to be invoiced\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internal Department Cost Centre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

External

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb State Postcode

**For all Research requests, please:**

**1**. Attach copy of letter of approval by Human Research Ethics Committee (HREC)

**2**. Attach copy of signed HIS Research Request Form

**If all information requested in this box is not supplied,**

**this form will NOT be actioned**

**Total:**

*(HIS use only)*

Please tick your requirements: **If left blank, only the current volume will be retrieved. Re-requesting additional records may incur additional costs.**

* Current volume only
* All volumes

**I hereby declare that I have read the terms and conditions on the reverse side of the Multiple Medical Record Request Form. I acknowledge that if this Request is not completed in full, the form will not be actioned until HIS receives a completed HIS Research Request Form.**

**Requestor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation/Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TERMS AND CONDITIONS**

The requestor agrees to the following terms of conditions of medical record access.

1. Records are retrieved once a week. If request involves more than 50 volumes records will be retrieved in batches.
2. All costs associated with record retrieval will be met.
3. The requestor agrees to view the medical records within 7 days of when they are made available. Medical records that are retrieved and not viewed within 7 days will be returned to storage, If required again, additional costs will be charged.
4. Payment of invoices shall be in accordance with Alfred Health’s standard payment terms and conditions (within 30 days of invoice).

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|  | **UR Number** | **Patient’s full name** | **HIS Use Only** |
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