Griffin Hospital

Medical Record Department

Institutional Review Board Approved Study

Name of Study:

______________________________________________________________________

______________________________________________________________________

Principal Investigator: ______________________________________

Organization Address:

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Phone Number: ______________________

Name of Reviewers:

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Estimated Number of Charts Requested: ______________________________________

Frequency of Chart Pulls: ________________________________________________

I UNDERSTAND THAT THE INFORMATION OBTAINED FROM ALL PATIENT RECORDS MUST BE KEPT STRICTLY CONFIDENTIAL AND USED IN AGGREGATE FORM ONLY. AT NO TIME CAN ANY PAGE OF THE MEDICAL RECORD BE COPIED OR REMOVED FROM THE MEDICAL RECORD DEPARTMENT BY THIS REVIEWER. IF DURING THE COURSE OF REVIEW, INFORMATION IS FOUND THAT CAN IMPACT ON THE PATIENT'S HEALTH, THIS INFORMATION WILL BE DISCLOSED TO THE PATIENT'S PHYSICIAN.

I UNDERSTAND THAT THE COST OF THE STUDY IS $10.00 FOR EVERY 20 CHARTS PULLED. ANY PULL OF LESS THAN 20 RECORDS WILL BE DONE AT A BASE COST OF $20.00. THE BILL WILL BE SENT TO THE ABOVE REQUESTOR ADDRESS AND WILL BE PAID IN FULL WITHIN 30 DAYS OF RECEIPT. PLEASE MAKE SURE TO LIST ALL REVIEWERS INVOLVED IN THE STUDY. IF REVIEWER IS NOT LISTED THEY WILL BE DENIED ACCESS.

Signature of Principal Investigator: __________________________________________

Date: ________________________

July 9, 2004