<table>
<tr><td rowspan="2"> </td><td>MEDICAL RECORD CONTENT / MANAGEMENT</td><td colspan="2">CODE : MC-F-134</td></tr>
<tr><td>PERMISSION TO ACCESS THE PATIENT'S MEDICAL INFORMATION</td><td>Edition
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</table>

Name of the Applicant requesting access*: ____

Specialty/Education/Function: ______________________________	***Affiliated Institution/University:*** ______________________________
Contact Number: ______________________________	***Email:*** ______________________________

Date of the access: ______/______/______; Time of the access: From _____:_____ to _____:_____

Reasons of the access/Purpose of Data Collection:

____

____

Access to:

- ☐ Laserfiche
- ☐ PACS
- ☐ HIS
- ☐ LIS
- ☐ Hard copy of the medical record
- ☐ Interviews of medical staff
- ☐ Interviews of patients
- ☐ Other : ______________________________

I hereby promise that all the information I access will be used confidentially and only as needed to perform my legitimate duties.

Signature of the Applicant
Name: **Date:**

Signature of the Head of Department
Name: **Date:**

Signature of the Medical Record Responsible
Name: **Date:**

Signature of the Hospital's Board Representative
Name: **Date:**

*Required Documents:

1. Univeristy ID/National ID for each participant
2. Study/Thesis Proposal
3. Case Report Form/Data Collection Sheet
4. Informed Consent Form
5. Dean's /Referral Letter for Study/Thesis
6. GB-F-01: Confideniality Agreement for each participant
7. Curriculum Vitae of all Professional participants
8. Copy of Ethics' Committee approval, if other sites are involved
9. GCP certificate for Human Research Subject: https://gcp.nidatraining.org for each participant.