Harris County Hospital District

HEALTH INFORMATION MANAGEMENT

Chart Request Form

DATE REQUESTED	DATE REQUIRED	PROTOCOL NUMBER

REQUESTOR NAME	DEPARTMENT/ORG.	PHONE NUMBER

BEEPER NUMBER	FAX NUMBER	E-MAIL ADDRESS

TITLE OF STUDY/PURPOSE OF REQUEST:

PRIMARY PHYSICIAN:

PERSONS REVIEWING CHARTS:

PERSONS WITH ACCESS TO INFORMATION:

INTENDED USE/RE-DISCLOSURE:

TYPE OF REVIEW (CHECK ONE): ☐ PUBLIC HEALTH ☐ OPERATIONAL ☐ BILLING
☐ RESEARCH ☐ QUALITY IMPROVEMENT ☐ EXECUTIVE REQUEST ☐ CASE MANAGEMENT

ACCESS TO PROTECTED HEALTH INFORMATION (PHI):
☐ Total Access (All PHI including MRN, SS#, Adress Phone #, DOB, Age, Age Range >80, Zipcode)
☐ Limited Access _____
☐ Comment _____

PROCESSING TIME: ☐ Standard (5-10 business days) ☐ STAT for Patient Care (needs HIM approval)
Signature _____

00	10	20	30	40
50	**60**	**70**	**80**	**90**

TOTAL NUMBER OF RECORDS REQUESTED	DATE COMPLETED	TIME COMPLETED

ACCOUNTABILITY SIGNATURE _____

RECEIVED BY IN HIM	DATE RECEIVED BY HIM	TIME RECEIVED BY HIM