



### HEALTH INFORMATION SERVICES

This form must be completed if access to Health Records is required.  
Please complete all questions and obtain the appropriate signature.

Principal Investigator:

**REB #:**

Name of Sponsor:

Study Start Date:

Study End Date:

Project Title:

**1. Summary of Services Requested**

- Estimated time period of study
- Estimated number of charts to be requested
- Rate you would like to receive charts

I have read HIS Research guidelines and agree to abide by the hospital policies governing health information (<http://pod/policies/Default.aspx>)

**Signatures:**

\_\_\_\_\_

Date

\_\_\_\_\_

Researcher

\_\_\_\_\_

Date

\_\_\_\_\_

HIS Research Coordination Clerk