ARROWHEAD
REGIONAL MEDICAL CENTER

Office of Research and Grants

Medical Record Request Form

Date			
Department			
Primary Investigator			
Email Address			
Phone Number			
Protocol or Case Number		Protocol #	
Protocol approved By IRB:	**Yes** ☐	**No** ☐	
Time Range Data Needed		**From:**	**To:**
Providing:	**ICD-10:** ☐ **ICD-9:** ☐	**Diagnostic:** ☐	**Procedure:** ☐
Please Indicate The Nature of Your Request Below:			
ICD10:			
ICD-9:			
Diagnostic:			
Procedure:			
Variables:			
Needed By:			
Comments:			
Submitted By:			
Please Submit this form to: hajjafarr@armc.sbcounty.gov (909) 580-6336 Please Attach the IRB Approval Letter with your submission			