ARROWHEAD REGIONAL MEDICAL CENTER

Office of Research and Grants

Medical Record Request Form

Date			
Department			
Primary Investigator			
Email Address			
Phone Number			
Protocol or Case title and Number			
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			