Annex No. 3

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*(University / Institution / Organization)*

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*(Faculty, Year, Group)*

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*(Name, Surname)*

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*(Phone number, E-mail address)*

To: Head of the Department of Medical Statistics

at the Hospital of Lithuanian University of Health Sciences Kauno klinikos

**REQUEST FOR PERMISSION**

Regarding data for research study at Kauno klinikos

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_

 Hereby I request to provide hospital case history / patient medical records identification numbers ac-cording to the following ICD-10-AM codes:

|  |  |
| --- | --- |
| ICD-10-AM CODES*(enter the required codes)* |  |
| Indicate what medical records of the subjects are required*(No of hospital case histories or Patients medical records identification No)* |  |
| Period for which you want to receive the medical records of the subjects |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *(Signature)* |  | *(Name and Surname of Student)* |