Centre hospitalier de Périgueux

# REQUEST FOR ACCESS TO MEDICAL RECORDS FORM

I – **Applicant's identity**

Surname:……First name: ……

Date of birth:……

Address:……

……. ….Tel:……Mobile:……..

Email address:……

**Acting as:**

| | |
|---|---|
| Patient | Patient Provide proof of identity/passport |
| Legal representative | Legal representative Provide copies of:<br>- identity card / passport of the applicant and of the minor,<br>- family booklet (where appropriate) or birth certificate.<br>If divorced, provide divorce certificate |
| Guardian | Guardian Provide copies of:<br>- identity card /passport of the applicant and of the protected adult,<br>- the order issued by the judge supervising guardianship. |
| Beneficiary (where the patient has died)<br>□ partner<br>□ brother / sister<br>□ father / mother<br>□ child<br>□ other relative | Provide copies of:<br>- applicant's identity card /passport,<br>- proof of beneficiary status (copy of family booklet or birth certificate or special contract),<br>- notarial deed, certificate of inheritance,<br>- and a copy of the death certificate.<br>You must give reasons for your request in application of art L.1110-4 of the Public Health Regulations.<br>□ know the cause of death<br>□uphold the patient's memory<br>□ defend his/her rights<br>□ other, please specify……<br>……<br>NB: unless the deceased has expressed a wish to the contrary (article L.1110-4 section 7 of the Public Health Regulations). |

II – **Medical record request**

Surname:……Maiden name……..

First name:……Date of birth:……

Stay(s) concerned: hospital department(s) and periods as a patient:

……from ……to ……..

……from ……to ……..

……from ……to ……..

Records required: copies will be invoiced along with current postal charges.

For information, please contact the Users' Department.

□ Hospital report or discharge letter

□ Results of examinations, state which:……..

□ Operation report

□ Consultation report

□ Nursing file

□ X-ray (reproduced on CD-ROM at the current price):

□ Entire record

Give details of your request:……

……

III –**Arrangements for accessing medical records**

□ **Send copy**:

□ to the applicant's address by recorded delivery with proof of receipt

□ to the address of the doctor listed below by recorded delivery with proof of receipt

Surname:……First name: ……..

Address:……

Tel:……

□ **Copies handed over in person in the department concerned**:

If you do not specify how the requested records are to be handed over, they will be sent to the applicant's address by recorded delivery with proof of receipt.

You will be contacted by the medical secretary via e-mail or telephone and informed of the date and time at which copies will be handed over.

□ **On-site consultation**:

□ I will come alone

□ I will come accompanied by another person

□ or by a doctor

I duly note that I will be accompanied by a doctor from the hospital to help me understand the medical information. I may ask for copies of the medical records (invoiced at the current price).

The hospital doctor may, if s/he considers it necessary, recommend that you are accompanied by a person of your choice for the on-site consultation of your file.

Please send this form and photocopies of civil status documents to:

**Madame La Directrice du Centre Hospitalier**

**80, avenue Georges Pompidou, CS 61205**

**24019 Périgueux Cedex**

Signed in (place) ……, on (date) .....Signature: