Ospedale Privato Accreditato
Hesperia Hospital Modena Spa

Medical Records Office
Tel. 059/449112 Fax 059/394840

I THE UNDERSIGNED ……………………………………………………………………………

Aware that in the event of false declaration or that, upon inspection, any of the following statements prove not true, I will be punished in accordance with art. 76 of D.P.R. 445/2000 of the penal code, under my own responsibility.

DECLARE THAT I AM

- Party directly concerned (capable and adult)……………………………………………………….
- Parent with responsibility for minor ……………………………………………………………
- Tutor/carer for ………………………………………………………………………………...
- Supporting administrator for ……………………………………………………………………….
- Stably cohabiting partner of …… years of Mr./Ms. ………………………………………..
- Legal/testamentary heir of ………………………………………………………………..

(The applicant hereby certifies that, given that the request is for health documentation pertaining to a deceased person, he or she shall take steps to inform any other heirs that he or she has collected said documentation).

REQUEST FOR A COPY OF THE MEDICAL RECORD FOR THE ABOVEMENTIONED PERSON

Date of hospitalisation ……………………………………Ward ………………………………..................

METHOD OF COLLECTION:

- PERSONAL

- POSTAL

- I DELEGATE MR/MS…………………………………………………………………...

PHONE NUMBER ………………………………………………………………………..

Mailing address ………………………………………………………………………………

POSTAL CODE………..................CITY…………………………………………………………………

ATTACHED FRONT AND BACK COPY OF IDENTITY DOCUMENTS OF DELEGATING AND DELEGATED PARTIES

Date……………………………. **Signature** …………………………………………………

Privacy policy. I the undersigned declare that I have been informed that for the purposes of processing this request personal data shall be treated also with computerised methods and that the owner is the accredited private hospital Hesperia Hospital Spa Modena and that all requests may be sent to the address indicated above.

Date…………………………… **Signature** ………………………………………………