Regionaal ziekenhuis
Heilig Hart Leuven

REQUEST FOR A COPY OF DATA FROM A PATIENT FILE

Patient's identity (please attach a copy of your ID card)

Name and surname: ……..

Address: ……

……

……..

Date of Birth: ……..

Phone number: ……..

I wish:
0 a shipment by post
0 to collect the data personally
0 sending via e-mail to my email address……..
(if files are not too large)
0 I would like my data to be transferred to the designated person (complete admission form)
0 doctor:……
0 other person: ……..

Applicant

0 is the patient himself
0 is NOT the patient himself *(fill in the details below)* **(always include a copy of your ID card please)**

Name and surname:
……..

Address:
……..

……..

Phone number:
……..

Relationship to patient:
0 parents or guardian of patient
For minor patients aged 15 years and over, we ask the patient's own consent
0 authorized confidant (see below *) 0 other (please attach certificate)

The desired data

0 **Hospitalization** on
department……..period/dates……

0 medical data
0 nursing data 0 access codes to view medical images 0 lab results

0 other:……

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0 **Consultation** with a service or doctor ……period/dates……

0 medical data

0 access codes to view medical imaging 0 lab results

0 other:… ……..

0 Other……

0 If you request **data from before the year 2000**

- Please indicate which doctors you need information from

……

……

- Do you agree to have your patient history from before 2000 entered, based on your national register number? bring into the current electronic patient file

o Yes

oh no

Motivation or reason for the request:

……

……

……

……

I agree to the procedure and provisions as stated in the explanation below.

Patient's signature …… Date……..

*** Authorization for a confidant or representative, designated by the patient, to receive copy of patient data**

Please attach a copy of your identity card

The undersigned patient/legal representative hereby gives

……

……(name), born on ……

(date) permission to the Regional Hospital Heig Hart Leuven to

… .....(name of *confidant or representative)* to provide the above-mentioned information from his/her patient file.

Patient's signature	Signature of confidant or representative	Date
……	……	……

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EXPLANATION OF COPY PROCEDURE

WHO CAN REQUEST A COPY?

1) the patient himself
2) a confidant, authorized in writing by the patient
3) the parents or guardian of a minor patient or of an adult who falls under the status of government
4) a patient representative:
   • who has been previously appointed by the patient to exercise the patient's rights in his place if and as long as he is unable to do so himself, provided written proof
   • if the patient is in fact unable to exercise his patient rights himself and at the same time no representative has been appointed by the patient, or if no representative acts, the rights will be exercised by the cohabiting spouse or the legal or de facto cohabiting partner

   • if this person does not wish to do so or is absent, the rights are exercised in descending order by: an adult child, parent, adult brother or sister and, if not, or in the event of a conflict between the above-mentioned: by the care provider concerned, where appropriate in multidisciplinary consultation.

Note 1: To protect the patient's privacy, access to or a copy (in whole or in part) may be denied to a patient's representative. This right can then be exercised by a professional designated by the representative.

Note 2: After the death of an adult patient, a copy cannot be provided. However, there is an indirect right of access through a healthcare professional. Survivors up to and including the second degree can request access to the hospital's records (see: *form for access to the records of a deceased patient).*

Note 3: After the death of a minor patient, the person acting as their representative at the time of death, as well as the patient's blood relatives up to and including the second degree, can request access to and/or a copy of data from the patient file. (See: *form for access to/ copy of data from the patient file of a deceased minor).*

PROCESSING your request

1) Send the completed and signed form together with a copy of your identity card to:
   Sacred Heart Regional Hospital
   to the Ombudsman
   Naamsestraat 105
   3000 Leuven
   or send it by email: ombudsdienst@hhleuven.be
2) The Patient Rights Act stipulates a period of 15 days (after receipt of your application) in which your request must be processed.