Regionaal ziekenhuis
Heilig Hart Leuven

REQUEST FOR COPY OF DATA FROM A PATIENT FILE

Patient's identity:

First and last name: ……

Address: ……

……

……

Date of birth: ……

Telephone number: ……

The applicant (tick as appropriate)

0 is the patient in question (enclose copy of identity card)

0 is an authorised designated healthcare representative (please complete the additional document enclosed and attach it together with copies of the identity cards of the designated healthcare representative and the patient)

0 is a legal representative (please complete the additional document enclosed and attach it together with copies of the identity cards of the designated healthcare representative and the patient)

The requested data relates to (tick as appropriate)

0 Admission to department …… from …… to ……

0 Medical data

0 Nursing data

0 Other: ……

0 Consultations with:

0 Doctor…… on ……

0 Doctor…… on ……

0 Doctor …… on ……

0 Log-in to my patient file to be viewed by others

0 URG/IVF data

0 If you are requesting data from before the year 2000

- Please indicate which doctors you need information from
  ……
  ……
- You agree to enter your patient history from before 2000, based on your national register number, into the current electronic patient file
  - Yes
  - No

Motivation or reason for the request

……
……
……

Method of delivery of the copy of the patient data (tick preference)

0 I would like my patient data to be sent to my home address

0 I would like the data to be transferred by e-mail (if files are not too large). Enter your e-mail address here: ……..

0 I will collect the copy myself

0 The following person will collect my copy or can receive the copy (consent form in attachment)
……

0 I would like my data to be transferred to the indicated person (consent form)

0 Doctor: ……

0 Other person: ……

I agree to the procedure set out and the associated conditions.

……

……

Signature of patient or representative

Once you have completed and signed this document and attached a copy of the identity card, you may:

- Hand it over at the reception
- Send it by e-mail to the head physician Prof. Dr. Verelst via directiesecretariaat@hhleuven.be
- Send it by e-mail to the ombudsman service at ann.willemans@hhleuven.be

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Attachment 1: Authorisation for a designated healthcare representative, appointed by the patient, to receive a copy of patient data

The undersigned patient/legal representative ……

……

Born on …… hereby grants permission to provide to Mr/Ms
……
……
……

a copy of his/her patient file.

Date: ……

Signature of the patient/legal representative

……
……

Identity details of the designated healthcare representative (copy of identity card to be attached)

……
……
……
……

Practice address of general practitioner or other designated physician:

……
……
……