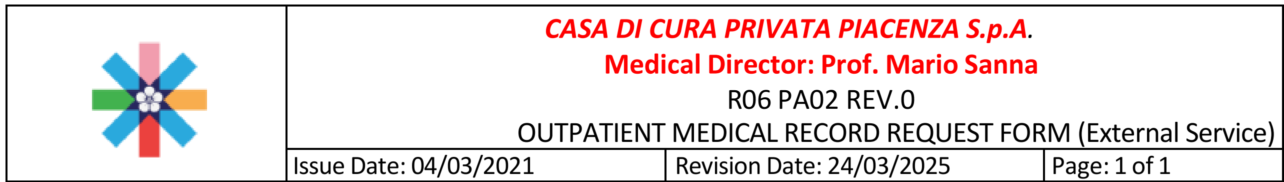

	CASA DI CURA PRIVATA PIACENZA S.p.A. Medical Director: Prof. Mario Sanna R06 PA02 REV.0 OUTPATIENT MEDICAL RECORD REQUEST FORM (External Service)		
	Issue Date: 04/03/2021	Revision Date: 24/03/2025	Page: 1 of 1

Dear User, We inform you that it is possible to request *ONLY after the discharge*, the release of a certified copy of the medical records related to your hospitalization.

I, the undersigned ____

Born in(place)______________________on(date)__________________________

Fiscal Code____

Phone contact information ____

E-mail contact ____

REQUIRES

☐ That I be issued a copy of the medical records relating to my admission to the

department ____

From ___________________________ till___________________________

OR

That I be given a copy of the medical records of Mr. and Mrs. ___________________________

admitted to the department ____

from________________________to________________________________

Aware of the requirements of Article 76 of Presidential Decree No. 445 of December 28, 2000 on the criminal liability I may incur in case of false statements, under my own responsibility, I declare that I am (in accordance with Articles 46 and 47 of Presidential Decree 445/2000)

- ○ an Heir
- ○ a Parent exercising legal authority
- ○ a Foster care under order no. ________ of __________issued by ________________________
- ○ a tutor ○ a trustee ○ a support administrator under order no.___________Of ___________ issued by___________
- ○ a Delegate (in this case, patient proxy is mandatory)

N.B. In implementation of precise legal obligations, the Company will carry out checks on what has been declare to certify its truthfulness and, in the event of a false declaration, will notify the Judicial Authority.

I WILL RECEIVE THE DOCUMENTATION AT THE FOLLOWING ADDRESS

Street/Square_____________________________n. _______ City_____________________

Prov. _______________ZIP CODE_____________ Country ___________________________

First and last name listed on the bell____

N. Interphone ____

THE PHOTOCOPY OF THE MEDICAL RECORD AT A COST OF **€ 25.74** (INCLUDING EXPENSES - ADDITIONAL COSTS FOR SHIPMENTS ABROAD DEPENDING ON THE COUNTRY), WILL BE SENT WITHIN 30 DAYS FOLLOWING THE BANK TRANSFER. BANK TO BE MADE OUT TO:

BENEFICIARY: **RJ45 SOC. COOP. ONLUS**
BANK: **BCC Agro Bresciano Soc. Coop.**
IBAN: **IT14F0857511201000000180374**
CAB: **11201** ABI: **8575** C/C: **180374**
REASON FOR PAYMENT: **PATIENT'S LAST NAME AND FIRST NAME** - PHOTOCOPY OF MEDICAL RECORDS

A VALID IDENTIFICATION DOCUMENT OF THE PATIENT AND THE APPLICANT, IF ANY, **MUST BE** ATTACHED TO THIS FORM.

DOCUMENTATION SHOULD BE MAILED TO ufficio.ricoveri@casadicura.pc.it

Piacenza, (date) ____________________ signature of applicant_____________________________

information in accordance with Article13 of Legislative Decree. n, 196/2003: Personal data, not particular, collected through this form will be processed by the owner Casa di Cura Privata Piacenza Spa for the sole purpose of providing you with the requested service in accordance with Art. 6 paragraph 2 b) GDPR. The data in this form will be processed for the time strictly necessary to manage your request. In order to provide you with the service referred to in this form it is necessary for us to obtain all the data indicated therein, without which it will not be possible to fulfil your request. The data will be processed by internal or external staff specifically appointed pursuant to art. 28 GDPR. You have the right to exercise the rights set forth in Art. 15 et seq. of the GDPR, including the possibility of lodging a complaint with the Privacy Guarantor. For any other information, please refer to the information already provided at the time of data collection or to the information on our website