MEDICAL RECORDS COPY REQUEST FORM

(To be sent to the following email address: s.morini@casadicurasgiovanni.it)

Or by fax at the following telephone number: 02-48705681

I, the undersigned .............................................................................................

resident in …………….. ………………….. in Via ………………………………… no. …….

request that a copy of the medical record concerning my inpatient stay is released.

Signature Date

……………………………………… ………………………

Note:

the following must be enclosed:

* Copy of Ordinary postal money order in the amount of €25.00 made out to the Casa di Cura San Giovanni, with reason: medical records request for Patient ..........................

Or:

* Copy of the bank transfer in the amount of €25.00 made out to the Casa di Cura San Giovanni, bank: Intesa San Paolo, IBAN: IT18G0306909563000006276176, with reason: medical records request for Patient ..........................

***Pursuant to Legislative Decree no. 196 of 30 June 2003, I authorise the use of my personal data.***