B.P. 381- SPRING CONCORDIA
97054 SAINT-MARTIN CEDEX

APPLICATION FORM FOR MEDICAL RECORDS

Articles R. 1111 – 1 à R 1111 – 8
Du code de la Santé Publique

I the undersigned: (Names/Surnames)
☐ Mr., name ---------- Surnames----------
☐ Ms, name (Specify the name and maiden and surnames) ----------
Phone number (s) ----------
Address: ----------

If necessary: Father, mother, legal representative or entitled (name et first name of the patient) ---------
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Date of birth: ----------

Asking to Mr. the Director of the LCF hospital the following record(s):
☐ Hospital report of---------- the ----------
☐ Main parts of the medical record
☐ Other documents (specify): ----------

Established by the hospital (Mark the compartments):
☐ In my name
☐ In the name of----------

I would like:
☐ This document to be sent to my family doctor at the following address:

☐ To consult the medical record on the spot (take an appointment with the medical information department specifying the presence of a doctor)
☐ A copy to be sent to my address by registered mail at my expenses according to the post office fee.
Copies of the file according to the order of the 1st of october 2001 will be charged as follow:

Price of photocopy format A4 (21 cm/29.7 cm) black and white printing	0.18 €
Price of photocopy format A3 (42 cm/59 cm) black and white printing	0.36 €
Price of radiological picture (unit price)	0.55 €
Price of CD (unit price)	2.75 €
Price of floppy disk (unit price)	1.83 €

Reason of request :

Informations to help us find the file faster (dates-services/departments of hospitalization- date of birth- Name, surnames, maiden name).

This form should be completed and signed accompanied in all cases of a copy of a ID or passport or family book for legal representatives or inheritance certificate for the entitled person and sent to: Monsieur le Directeur, Centre Hospitalier LC/F, BP 381 Spring Concordia, 97054 Saint-Martin cédex.

Date Signature