The undersigned Mr./Mrs. _____

Born on ___/___/___ in _____

Residing in _____ Province _____

Road _____ No. _____ Postcode _____

Telephone number of the applicant for possible communication by the Hospital: _____

REQUESTS

the release of no. _____ copy/copies of the following:

Duplicate of the radiography on digital support **Cost € 12.50**

□ Radiography taken on ___/___/___ type _____

□ Ultrasound scan taken on ___/___/___ type _____

□ CAT scan taken on ___/___/___ type _____

□ Magnetic resonance taken on ___/___/___ type _____

□ Coronary angiography taken on ___/___/___

carried out:

□ during hospitalization in the _____ department from ___/___/___ to ___/___/___

□ as an outpatient service on ___/___/___

Date ___/___/___

Signature of applicant

_____

USEFUL INFORMATION

Payment must be made at the radiology CUP cash when the copy is requested. The CUP cash is on basement floor one, and is open from Monday to Friday from 8.00 am to 1.00 pm; at other times and on Saturday payment can be made at the other CUP cash desks.

The presence of the holder is needed to collect medical records (medical records, radiological examinations, reports, etc.). If the holder cannot be present, a written authorization is needed. For the authorization, please fill out the module available from the Information Office.

The copy of the radiological test can be collected from the Radiology counter, on basement floor one, from Monday to Friday 8.00 am to 1.00 pm and on Saturday from 8.00 am to 2.00 pm.