Personal request for a medical history/ radiological images

Patient (Please complete using BLOCK CAPITALS)

First name, family name

Title

Address

Social insurance number + date of birth

Telephone number

Email address

If the request is being made by **someone OTHER THAN the patient himself/ herself,** a valid document of authority must be also attached (not necessary in the case of parents/ legal guardians).

☐ Authorised representative ☐ Trustee/ Healthcare agent ☐ Parent/ legal guardian/ legal custodian

First name, family name

Title

Address

Telephone number and email address

Social insurance number + date of birth

Relationship to the patient

☐ Spouse ☐ Partner ☐ Daughter/ son ☐ Mother/ father ☐ _____

As proof of identity/ proof of legitimacy, I have attached a copy of my

☐ Driving license ☐ Passport ☐ _____

Documents

Hospital/ clinical department concerned

Hospital stay/ treatment (from – until)

☐ Inpatient ☐ Outpatient

☐ Discharge letter(s) ☐ Results _____ ☐ Radiological images ☐ Other _____

By signing this form you confirm the correctness of the information provided.

Place, date

Signature

tirol kliniken
universitätskliniken
innsbruck

MEDIZINISCHE UNIVERSITÄT
INNSBRUCK

Please send form to:

☐ Abteilung Verträge und Koordination	lki.vertragsangelegenheiten@tirol-kliniken.at	Fax: 050 504-67 220 06
☐ Univ.-Klinik für Radiologie	lki.ra.radadmin@tirol-kliniken.at	Fax: 050 504-289 92
☐ _____		

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