Vivalia
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FORM TO REQUEST A COPY OF MEDICAL RECORDS

PATIENT IDENTITY

NAME _____ **FIRST NAME** _____

Date of Birth : ____/____/____ **Email:** _____

Address: _____

Postal code : _____ **Location:** _____

Country : _____ **Phone number :** _____

- Emails are only used to exchange information relating to the request, not to transfer a copy of the file.
- If the patient is deceased and has not objected, only the spouse, legal or common-law partner, and relatives up to and including the second degree may request indirect access to the file, provided they submit a justified and reasoned request. This access may only be granted via a physician.

APPLICANT'S IDENTITY

(to be completed only if different from the patient: authorized individual, parent, guardian, legal representative, attorney, physician...)

NAME _____ **FIRST NAME** _____

Date of Birth : ____/____/____ **Email:** _____

Address: _____

Postal code : _____ **Location:** _____

Country : _____ **Phone number :** _____

The applicant must attach to this request written proof of their right to request a copy of the patient's file (power of attorney signed by the patient, guardianship order, etc.).

RECIPIENT'S IDENTITY

(to be completed only if distinct from the patient and/or the applicant)

NAME _____ **GIVEN NAME** _____

Date of Birth : ____/____/____ **Email:** _____

Address: _____

Postal code : _____ **Location:** _____

Country : _____ **Phone number :** _____

COPY OF THE FILE

- ☐ USB key sent by registered mail to the address provided
- ☐ USB key to be collected from the Medical Department office on site

The accurate and comprehensive display of a copy on a digital medium necessitates that the recipient possesses a current Internet browser.

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VIVALIA SITE(S) INVOLVED – Multiple boxes may be selected.

- ☐ Vivalia Hospital in **Arlon** (CSL)
- ☐ Vivalia Hospital in **Bertrix** (CUP)
- ☐ Vivalia Hospital in **Bastogne** (CHCA **effective** 01/07/2021)
- ☐ Vivalia Hospital in **Bastogne** (formerly IFAC **prior** to 01/07/2021)
- ☐ Vivalia Hospital in **Libramont** (CHCA)
- ☐ Vivalia Hospital in **Marche**
- ☐ Vivalia Hospital in **Virton**

DOCUMENTS REQUESTED

☐ Complete version of the document

☐ Partial copy Period: from ____/____/____ At ____/____/____

Specialty(ies): .....

.....

.....

↳ Beyond three specialties, the transmission is conducted by default in full copy.

- ☐ Consultation and hospitalization letters
- ☐ Medical imaging scans
- ☐ Medical imaging protocols (X-rays, MRIs, ultrasounds, etc.)
- ☐ Laboratory test results
- ☐ Nursing records
- ☐ Pharmaceutical prescriptions
- ☐ Others: .....

The file will be sent within **two weeks** of receipt of the request. If a justified emergency requires faster delivery, please specify this by email.

This request, along with a **copy of the applicant's ID** (and, if applicable, a signed power of attorney from the patient, accompanied in this case by a copy of the patient's ID), should be sent to the following email addresses with the subject line "**Request for copy of file – Patient's name**" or submitted to the reception desk of the hospital concerned:

- Vivalia Medical Department – **Arlon**: directionmedicale.csl@vivalia.be
- Medical Directorate Vivalia – **Bertrix**: dmc@vivalia.be
- Vivalia Medical Department – **Bastogne/Libramont**: demandedossier.chca@vivalia.be
- Vivalia Medical Department – **Marche**: secretariat.direction.medicale.marche@vivalia.be

! Please ensure that all copies of documents you send us (whether scanned, photographed, or photocopied) are entirely legible.

AREA DESIGNATED FOR THE AGENTS RESPONSIBLE FOR THE REQUEST

- Agent responsible for duplicating the file: .....
- Agent responsible for sending the copy: .....
- Date of dispatch: ...../...../.....

Date:

Applicant's signature: