

Date de création : 23/01/2018 (V1) – Date de la dernière modification : 21/07/2023 (V3)

## References

- ↳ Law to march 4 2002, the rights of the patient\*
- ↳ Article 2 of the decree to April 29,2002 on access to personal information owned by professional and health institution (articles L1111-7 and L1112-1 of the public health code).
- ↳ Order of 5 March 2004, good practice recommendations on access to information about the health of a person.

**Form to return duly completed and signed :**  
**Centre Hospitalier d’Ajaccio**  
**Direction des Relations avec les Usagers**  
**1180 Route A Madonuccia**  
**20 090 AJACCIO**

## PATIENT’S IDENTITY

Mrs, Mr : .....


Date of birth: ..... N°  : .....

Address : .....

## APPLICANT QUALITY ( if the applicant is not the patient)

Mrs, Mr : .....

Address : .....

N°  : .....

 Check the boxes corresponding to your choice.

### QUALITY OF THE APPLICANT :

- You have parental authority, acting as a:  father  mother  legal guardian
- You are mandated (attached the patient’s letter)
- You are entitled to access to a medical file in case of death of your father, mother or children:  
Specify the motivation (Art L1110-4) CSP\*
  - Know the causes of death
  - Defend the memory of the deceased
  - Rights to be argued

**NB : If the person has expressed a contrary intention, this request cannot be accepted.**  
(Art.L 1111-5) Art 6 of the decree of March 29, 2002

## VOUCHERS

- Photocopy front and back identity card or passport
- Photocopy attesting parental authority (family record book, judgement or order rendered)
- Photocopy attesting to the exercise of guardianship (judgement or order rendered)
- Photocopy or document attesting to the status of rightful owner (notarial act or act of civil status)
- Photocopy of the life insurance policy of which you are the beneficiary

**TRANSMISSION OF THE MEDICAL FILE**

I request the communication according to the following modality:

**Send home or next address**

Name- First name : .....

Address: .....

**Send to the doctor of your choice**

(Art.L1111-7 CSP)

Name- First name:

.....

Address : .....

.....

**Withdrawal at the office of relations with the users**

**On-site consultation (free)**

(Art.R 710-2-1 CSP)

Make an appointment with the doctor at the secretariat of the service concerned..

**REASONS FOR THE REQUEST**

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.....  
.....

**TYPE OF REQUEST**

You wish :

**The entire medical file.**

**The following elements :**

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.....  
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**Patient's dates of stay**

**Care Service**

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**The lack of supporting documents of you, within 3 months after sending this for, will lead the closing of the process of access to your file or that of a close.**

*I undertake to pay to Ajaccio Hospital Center the reproduction fees for requested documents (0.18€/page format A4 and medical imaging contretype) as well as the postage costs*

Date .....in .....

**Signature**