Request for copies of medical records

(ver. 1.0)

by next of kin, legal guardian etc.

PATIENT DATA

Name:	**Personal identity number:**

REQUESTED DOCUMENTS

Request for documents from following hospitals:			
Sahlgrenska hospital	Mölndal's hospital	Östra hospital	Högsbo hospital

Department / clinic:	**Dates: (years)**

Other information (Doctor's name, name/number of ward etc.):

Requested documents:			
Medical record	X-ray treatment report	Lab report	Others: _______________

The first 10 pages are free of charge, thereafter a fixed charge of 50 SEK + 2 SEK per page (maximum fee 300 SEK).Cash on delivery plus postal charges.

Requestors name:	
Street name & no:	
Post code:	**Town / city:**
Telephone number (daytime):	**Mobile phone number:**

POWER OF ATTORNEY

I confirm that I give my permission to the requestor to request my medical records by this signature or enclosed power of attorney. This permission is valid solely for this specific request.

Date:	**Signature:**
Printed name:	

Send request to: Sahlgrenska Universitetssjukhuset
Arkiv och informationsstruktur, journalbeställning
413 45 Göteborg

Telephone: **Direct** +46 (0)31 343 91 00 **Fax** +46 (0)31 25 51 63
Visiting address: Torggatan 5, 431 35 Mölndal
Visiting hours **Weekdays** 09:00–11:00
as well Monday, Wednesday, Thursday and Friday 13:00-14:00

VÄSTRA GÖTALANDSREGIONEN
SAHLGRENSKA UNIVERSITETSSJUKHUSET

Sahlgrenska University Hospital
Arkiv och informationsstruktur
Switchboard +46 (0)31 342 10 00