BON SECOURS HEALTH SYSTEM

Medical Record Request Form

Surname	
Forename	
Date of Birth	
Phone number	
Current address	
Previous address if applicable	
List of records requested (if known)	
Proof of Identification	Please X which one of the following you will be providing: 1. Birth Certificate __ 2. Passport __ 3. Driving License __ 4. Other (Please specify) _____
Hospital	Please X the facility where the requested medical records are retained (if known): 1. Cork Hospital __ 2. Cork Care Village __ 3. Dublin Hospital __ 4. Galway Hospital __ 5. Limerick Hospital __ 6. Tralee Hospital __
Please return completed form to the relevant Data Protection Representative **NOTE:** Requestors must present themselves to the Relevant Hospital Medical Records Dept by Appointment. If this is not possible please contact the Dept so that practical alternate arrangements can be made. In either case it will be necessary to verify identification.	