GUEST REQUEST FOR MEDICAL RECORDS

Ship:	**Sailing date:**
Full Name of Patient:	**DOB of Patient:**
Name of Party requesting records:	**Relationship***
Address to which records are to be sent:	**City:**
State/Province/Country (include postal code):	**Phone:**
E-Mail address:	**Fax number:**

* ***If the records of a minor are requested a birth certificate or form identifying requestor as a guardian is required***

Alternative means of delivery:

I do not want to receive the medical records by post, but instead by:

[ ] fax to the above mentioned fax number
[ ] e-mail to the above mentioned e-mail address.
It is your responsibility to ensure that no unauthorized person has access to your email address or fax. Please note that emails we send will not be encrypted. We cannot guarantee that unauthorized persons cannot access information sent.

I, (Print full name of REQUESTING PARTY) _____
authorize Royal Caribbean Cruises LTD / Celebrity to send a complete copy of the medical records and X-rays of the patient identified above to the address listed above.

Signature Date If signed by legal representative, relationship

Indicate documentation that you are requesting

[ ] Duplicate of Medical Services Bill- No charge

[ ] Copy of all medical records- No charge

[ ] Copy of X-ray- No charge

Completed Request form and copy of identification (Drivers License/ passport)are required and should be mailed to:

Royal Caribbean/ Celebrity Risk Management Department
Attn: Medical Services
1080 Caribbean Way
Miami FL 33132

Requests for Medical Services Bill **only** can be faxed to (786) 264-9682

For Office Use Only		
Date of request:		
Date records sent:		