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:**

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

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- $25.00

[ ] Copy of X-ray- $50.00

Checks/ money orders should be made payable to:
Royal Caribbean Cruises Ltd.

Completed Request form, copy of identification (Drivers License/ passport) and payment (if indicated) should be mailed to:

Royal Caribbean/ Celebrity Risk Management Department
Attn: Medical Services
1050 Caribbean Way
Miami FL 33132

Requests for Medical Services Bill **only** can be faxed to (786) 264-9677

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