Twój Doktor
Gabinety Medyczne

APPLICATION FOR THE RELEASE OF MEDICAL RECORDS

Applicant's details: ……

PESEL number: ……. Date of birth*: ……..…….

ID document type and number (if applicable): …….

Patient details (if different from the applicant): …….

PESEL number: ……. Date of birth*: ……..…….

ID document type and number (if applicable): …….

I am applying for:

☐ a copy of the medical records

☐ access to medical records for inspection

Type of medical records:

• Department / Clinic / Laboratory name: ……..

• Treatment period: …….

Delivery method for the requested records:

☐ I will collect the records in person

☐ Please send to the following address: ……

☐ The records will be collected by an authorized person:

- Full name: ……

- ID document number: ……

I declare that I agree to cover the cost of making copies of the medical documentation, in accordance with applicable regulations.

(Date and legible signature of the applicant/)

……

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CONFIRMATION OF RELEASE OF DOCUMENTATION

Documentation:

☐ Sent by post to the indicated address on: ……

☐ Collected in person by the patient

☐ Collected by a person authorized by the patient:

☐ Authorization included in medical records

☐ Authorization included in this application

☐ Separate written authorization (attached to the application) ……

ACKNOWLEDGEMENT OF RECEIPT:

I confirm receipt of the requested documentation.

(Date and signature of the person receiving the documentation)

……

Identity confirmed based on (type and number of document): …….

(Date and signature of the employee releasing the documentation:)

……