

## REQUEST ACCESS TO MEDICAL RECORDS

### Patient Details:

Name and Surname: .....

ID document: .....

Residential address: .....

Contact phone number: .....

### Legal representative data:

*(fill in if patient is a minor, partially or completely deprived of legal capacity)*

Name and Surname: .....

Residential address: .....

### Request to:

- access to medical records- copy
- access to medical records, view only

Type of medical records:

- medical history/examination results/referrals/certificates: .....
- treatment period: .....

Requested documentation:

- I will collect personally from Ginemedica ul. Podwale 83 lokal 9 ,50-414 Wrocław.
- Please send it via email: .....
- Will be collected by an authorised person from Ginemedica ul. Podwale 83 lokal 9 ,50-414 Wrocław:
  - Name and Surname: .....
  - Residential address: .....

.....  
date and patient signature

### Acknowledgement receipt :

Date: .....

Agreed date of collection/ mail/ view only: .....

Employee signature: .....

**CONFIRMATION OF DOCUMENTATION HANDOVER**

Documentation:

- Email sent date: .....
- Personal Collection date: .....
- Authorised person collection date:
  - Authorisation included in medical records,
  - Authorisation included in this form,
  - Separate authorisation (attached to the form)

.....  
date and employee signature

**Acknowledgement receipt :**

I hereby confirm the collection of requested documentation.

.....  
date and signature of the recipient

The identity of the recipient is confirmed by following identity document:

- ID
- passport
- license
- residence card

.....  
.....  
Date and employee signature