

Patient Request for the Release of Medical History or Other Medical Documentation

Patient Information

Full Name

PESEL

(Personal Identification Number)

Date of Birth

Telephone

Scope of Documentation (e.g. from which clinic/department)

Time Period Covered by the Documentation

☐

From the moment the medical record was created

☐

from

to

Method of Receiving the Documentation

☐

I will collect it in person

☐

Please send it by registered mail to the following address:

☐

Please send it electronically to the following email address:

☐

A person authorized by me in writing will collect it in person:

Full Name of the Authorized Person

PESEL or ID Card Series and Number

If collected in person, the medical documentation must be picked up within 30 calendar days from the date of request fulfilment.

Date and Signature of the Patient

Date and Signature of the Employee Receiving the Request