VEDICLINIC
KLINIKA DLA MĘŻCZYZN

APPLICATION FOR ACCESS TO MEDICAL RECORDS

Details of the person requesting the documentation	
Name and surname	
PESEL	
Residential address	
Contact telephone number	

Details of the patient whose records are being kept *(complete if the applicant is a person other than the patient)*	
Name and surname	
PESEL	

I am requesting a copy of my medical records

Type of medical records	
Specialist/consultation/examination	
For the period/ from	

Requested documentation:

- ☐ I will pick it up in person
- ☐ please send to the address (Traditional mail):

**Note! The fee for issuing archival medical documentation is PLN 0.30/ page + PLN 8.00 shipping via Polish Post (medical documentation is issued free of charge immediately after the visit)*

- ☐ will be picked up by an authorized person:
  - Name and surname: .....
  - ID card number: .....

I declare that I undertake to bear the costs of making copies of medical records, in accordance with applicable regulations.

....

Place, date Applicant's signature

CONFIRMATION OF RECEIPT OF THE APPLICATION:

Date: ..... Agreed pickup/shipment date: .....

Employee's signature: .....

CONFIRMATION OF DOCUMENTATION ISSUANCE

Documentation:

- ☐ sent by post to the address provided on the day: .....
- ☐ collected personally by the patient,
- ☐ collected by a person authorized by the patient:
  - authorization in medical records,
  - authorization in this application,
  - separate written authorization (attached to the application).

Charges were levied at: .....

.....

Date, signature of the employee issuing the documentation

CONFIRMATION OF RECEIPT

I confirm receipt of the requested documentation.

.....

Date, signature of the person receiving the documentation

Identity of the person receiving the parcel confirmed on the basis of:

.....

(document type and number)

.....

Date, signature of the employee issuing the documentation