Krajmed Centrum Nowoczesnej Laryngologii
Spółka z ograniczoną odpowiedzialnością
Ul. Wałbrzyska 11 lok. 55, 56; 02-739 Warszawa
Tel. 22/458-69-69, fax: 22/458-69-70

AUTHORIZATION TO GIVE OUT MEDICAL DOCUMENTATION/TEST RESULTS

Patient's details

Name and surname: .....

PESEL: | | | | | | | | | | | Address: .....

..... Phone: .....

I, the undersigned, holder of the identity card: series:: ..... number: .....

authorise:

1. Mr/Mrs: .....

PESEL: | | | | | | | | | | |

holder of the identity card: series: ..... number: .....

to collect my medical documentation/ test results: .....

2. The personnel of Centrum Medyczne Krajmed to send my medical documentation/test result:

☐ by e-mail to: .....

☐ to the following address: .....

.....

....

Date and the Patient's legible signature

Date and legible signature of the person collecting the documentation/test result

....

Date and employee's legible signature

Confirmation that the result has been sent