

.....  
Date

## REQUEST FOR MEDICAL RECORDS

### Patient's details

Name and surname: .....

PESEL: 

--	--	--	--	--	--	--	--	--	--	--	--

*\* For patients who do not have a PESEL number – type and number of the document confirming their identity*

Type: ..... number: .....

Please provide the following medical records:

1. ....
2. ....
3. ....
4. ....

.....  
Patient's signature

.....  
Employee's legible signature

I have received medical records:

.....  
Date

.....  
Patient's signature

\* fill in if applicable