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

Request for a copy of medical records

Patient

First and last name .....

PESEL: | | | | | | | | | | | Telephone nr.: .....

Patients that do not have a PESEL are required to provide a photo ID for verification.

Type of ID: ..... number: .....

I am requesting a copy of the following medical records:

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

Requested records:

- ☐ please make accessible on my secured Krajmed Patient Portal
- ☐ I will collect personally
- ☐ Please e-mail to the following address*: .....
- ☐ Please mail to the following address*: .....
  .....
- ☐ Will be collected by a trusted person pointed by me:
  I hereby authorize:
  Mr/Mrs .....
  ID nr: .....
  to collect my medical records listed above

*In case of discrepancy between information given in this form and information in patient's medical records this request will be held until the issue is resolved. Krajmed Medical Centre will contact the patient with further instructions.

.....
date and legible signature of patient/parent/legal guardian

I acknowledge the receipt of requested medical records listed above (pertains to collection in person):

.....
date and signature of patient/parent/legal guardian

Identity of a person collecting the medical records was confirmed by:

Type of ID: ..... number: .....

.....
date and signature of a person realising the documents