Bydgoszcz, on …….

Centrum Medyczne Gizińscy Sp. z o.o.
ul. Leśna 9a
85-676 Bydgoszcz

APPLICATION
for access to medical records

I. Data of the person submitting the application for the issuance of medical records:

First name and last name

…… ……. Address

…… .. PESEL:

……

II. Data of the patient to whom the access to medical documentation relates:
(if the applicant is a person other than the patient)

First name and last name ……

…… Address …… ……..

PESEL: ……..

I am requesting access to medical records:

- ❑ all medical records
- ❑ information card (excerpt)
- ❑ medical documentation covering the period: ……
  ……..
- ❑ selected documents in the medical records, i.e.:
  a) ……
  b) ……
  c) ……

Please provide medical documentation in the form of:

- ❑ inspection at the place where the service is provided with the possibility of making notes or taking photos
- ❑ copy/statement
- ❑ copy of medical records/printout
- ❑ original with acknowledgment of receipt, subject to return after use, at the request of the authorities public or common courts
- ❑ IT data medium (CD)
- ❑ other form of providing access to medical documentation (e.g. photos)……

Receipt of shared medical documentation:

- ❑ personal collection at the Centrum Medyczne Gizińscy
- ❑ collection by an authorized person

- ❑ shipping to: ……
- ❑ shipping to the email address:
  ……

I declare that due to the confidentiality and protection of personal data, I accept the mode of sharing medical records provided for in art. 26 and Art. 27 of the Act on Patient Rights and the Patient Ombudsman (Journal of Laws of 2017, item 1318, as amended).

If the documentation is requested by a person who is not authorized in the documentation, then that person is obliged to present a written authorization from the patient, which should be submitted together with the application.

…… ……

Place, date Signature of the applicant

RECEIPT CONFIRMATION

I confirm the receipt of medical documentation ……

Data and signature