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| **PATIENT’S MEDICAL RECORDS REQUEST FORM****Warsaw, date:** \_\_\_\_\_\_\_\_\_\_\_ |
| **1. Applicant’s data:**First name: Last name:Pesel ID number:  | Address:Contact phone number: |
|   **Please issue a photocopy of my medical records concerning:** A diagnostic test: All medical records available: Total number of pages copied:(to be filled out by Nukleomed staff, not patient) |
| **2. Patient’s data (if the applicant fills out the request on the patient’s behalf):** |
| First name:Last name:Pesel ID number:  | Address:Contact phone number: |
| **Relationship with the Patient:** legal guardian  authorized representative |
|  Applicant’s signatureNukleomed receptionist’s signature |
| **CONFIRMATION OF RECEIPT** **Warsaw, date:** \_\_\_\_\_\_\_\_\_\_\_ |
| Hereby I confirm the receipt of the requested medical records copies.Total number of pages copied: \_\_\_\_\_\_\_\_\_\_Applicant’s signature |