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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 signature  Nukleomed 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 | |