I hereby request of the following medical records of mine.

Patient data:	Health service information:
…… (name of patient)	…… (type of service)
…… (address)	…… (date of procedure)
…… (date of birth / PESEL)	…… (department)

Form of the release of medical records:

☐ preparing a paper version – to be collected in person

☐ sending via email : …… ……
(e-mail address) (telephone number)

☐ sending by registered mail: ……
(address)

…….
(date and legible signature of the patient / patient's legal representive)

…….
(date and legible signature of the clerk accepting this request)

Consent of the Medical Director

…….
(date and legible signature of the Medical Director)

Confirmation of receipt of medical documentation (in the case of personal collection).

…….
(quantity)

…….
(date and legible signature of the patient / patient's legal representive / person authorised by the patient)

…….
(date and legible signature of the clerk accepting this request)