FIZJOSPORT®
centrum rehabilitacji funkcjonalnej

Kraków, date: ……

REQUEST FOR SHARING A MEDICAL RECORDS

(Please complete with a block letters)

1. APPLICANT

First name and last name:…… Date of birth:……

PESEL: …… Address:……

…… Phone number:……

Please provide a medical documentation: (please mark X in the appropriate box)

☐ issuance of a printout or PDF file

☐ checking at the premises of the medical entity

Please complete only if the application is submitted by a person other than the patient to whom the documentation relates.
DATA OF THE PATIENT:

First name and last name: …… Date of birth: ……

PESEL: …… Address: ……

2. LEGAL TITLE TO OBTAIN DOCUMENTATION

☐ the application is submitted by the patient

☐ the application is submitted by the patient's statutory representative

☐ the application is submitted by a person authorized by the patient (original authorization should be attached)

3. THE DOCUMENTATION FOR PHYSIOTHERAPY TREATMENT

Within: (provide specific dates or a date range).. ……

4. METHOD OF RECEIPT OF THE DOCUMENTATION: (please mark X in the appropriate box)

☐ sending the PDF file to the email address: ……

☐ I will pick up the documentation in person at the premises of the medical entity

☐ I authorize to collect the medical documentation person: ……

……, holding identity card no: ……

☐ please send the documentation to the address specified in point no. 1, by registered mail.

5. STATEMENT

I declare that I have read the instruction contained in the order regulations of the medical entity, in Annex 1, and available on the website (www.fizjosport.krakow.pl). I understand and accept the method and mode of providing medical documentation and I declare to cover the costs of its implementation and possible shipping. I declare that any risk related to sending the documentation shall not be burne by the medical entity.

……

applicant's signature

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6. APPLICATION ISSUING CONFIRMATION (Does not apply when submitting documentation via email)

After verifying the identity of the recipient, I confirm the issuance of a copy of the medical documentation:

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(signature of FIZJOSPORT's employee)

I confirm receipt of the requested medical documentation:

…… ……

(signature of the recipent) (date of receipt)