REQUEST FOR COPIES OF HEALTH DOCUMENTATION

First and Last name of patient: ____________________________ Identification document: ____________________

Date of birth: ____

Address: ____

Phone: ____

IF THE APPLICANT IS NOT A PATIENT

Relationship to the patient: ___________________________________

First and Last name: _______________________ Identification document: ____________________

Date of birth: ____

Address: ____

Phone: ____

I am ordering copies of the exams and or images (circle) from medical documentation:

	Type of investigation	Date
1.		
2.		
3.		

The documentation will be prepared within 5 working days from the date of the request.

The payer of copies is the requester of the desired documentation.

Copies prepared by	Exam	Images
First and Last name:		
Signature:		
Date:		

Copies taken by	Exam	Images
First and Last name:		
Signature:		
Date:		

☐ I am allowing transfer of my /patients personal data to third countries (in case of e-mailing or using online services (wetransfer etc) to transfer exam images to a specific location. *GDPR.*

Date, location ____________________________________ Signature: _________________________