REGULATIONS FOR SHARING INFORMATION AND DISCLOSING MEDICALRECORDS IN INSTITUTE OF MOTHER AND CHILD

Warsaw, date .............................

# To Deputy Director of Clinical Affairs

# Institute od Mother and Child

# Kasprzaka St. 17A

# 01-211 Warszawa

Phone numer: 22 32-77-050

 e-mail address: dokumentacja.medyczna@imid.med.pl

## APPLICATION FORM FOR MEDICAL RECORDS

I apply for the first time: 🞏 I reapply 🞏

Hereby, I apply for copies of patient’s medical records. Patient’s data:

Name and last name  ..................................................................................................................................

Address ...................................................................................................................................

Date of birth ..................................................Place of birth............................................................

PESEL number (personal identity number).........................................................................................

Treated at (clinic / medical unit) ………………………………………………………………

Dates of treatment....................................................................................................

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Copy |  | Certified copy of the original records |  | Recording on electronic storage medium |
|  |  |  |  |  |  |
|  | Scan sent via e-mail\* |  | E-mail address: ……………………….……………………………………... |  | Other (extract etc.) |
|  |  |  |  |  |  |
|  | Copy of description of surgical intervention |  | Prints/copies of test results  |  |  |

\* Records sent in a form of a scan may contain not more than 15 pages and does not apply to a certified copy

**I have been acquainted with the applicable price for the requested services in accordance with the Institute’s Price List.**

**APPLICANT’S DATA:**

Name and last name.....................................................................PESEL number.......................................

Address....................................................................................................................................

Phone number....................................................................................................................................

Type of ID............................................... number of ID .....................................

I declare that due to the confidentiality and protection of personal data, I accept the procedure of sharing the medical records referred to in art. 26 and 27 of the Act on Patients' Rights and Patient's Rights Ombudsman (Journal of Laws of 2009, No. 52, item 417, as amended) and that I will cover the entire cost of making and copying the above documentation, determined in accordance with the provisions of Art. 28 of the above-mentioned Act on Patient Rights and the Patient Ombudsman..

**Hereby I give my consent to issuing the copy of my medical records (applies to a patient who is 16 years or older and is not the applicant).**

………………………………………

Date, applicant’s signature

…………………………………….

Date, patient’s signature

**Deputy Director’s decision**

**I confirm the medical documentation has been verified**

**Signature of the head of the clinic/unit**

**DECLARATION OF RECEIPT OF MEDICAL DOCUMENTATION AFTER PAYMENT (FEE)**

|  |  |  |
| --- | --- | --- |
| **1.** |  | **Personal receipt (payment at cash desk in Institute)** |
|  |  |  |
| **2.** |  | **Post mail (prepayment/bank transfer)** |
|  |  |  |
|  |  |  |

I declare that at (date) ................................................ I collected patient’s medical records

......................................................................................................................................................................

(patient’s name and last name)

Number od pages: ................................ Fee:……………………………………...

............................................................

Date, cashier’s signature

.............................................................. ..................................................................

Date, applicant’s signature Date, Institute’s employee’s signature