REQUEST APPLICATION FORM OF PATIENT'S MEDICAL RECORD

APPLICANT INFORMATION	
LAST NAME:	
FIRST NAME:	
FATHER'S NAME:	
MOTHER'S NAME:	
ID CARD No.:	
CONTACT PHONE NO.:	

APPLICATION

I hereby request a copy of my medical record concerning my hospitalization or any other medical examinations for the time period from ___/___/____ to ___/___/____, which will be used for _____ .

The copy of my medical record:

☐ Will be received by me, upon display of my ID Card, or a third party, upon display of proper authorization, validated by a competent Citizen Service Center (KEP) or police station.*****

☐ Will be received by a person authorized by me, upon display of his/her ID Card *(in this case, the authorization below must be filled in).******

☐ Will be sent to me by courier or registered mail to the following address:

Street/Area:_____ Number:_____ Postal Code_____

Mobile phone number:_____ Other phone number:_____

AUTHORIZATION

I hereby authorize _____ of (*father's name*) _____ with ID Card No. _____, to receive a copy of my medical record from the Medical Records Department of HYGEIA Hospital, upon display of his/her ID Card.

APPLICANT	[full name & signature]	**DATE**	
RECIPIENT	[full name & signature]	**DATE**	

***** *Copies of Medical Records may be received* ***daily, 07:30 – 15:30,*** *from the Medical Records Department in five (****5) working days*** *after the patient's discharge date. For further information, please contact* ***+30 210 686 7488.***

HYG_F845en/ 3η / 15.04.2019