…… date…….
NAME AND SURNAME

……..
DATE OF BIRTH

Niepubliczny Zakład Opieki Zdrowotnej
ELEKTORALNA DENTAL CLINIC
Ul. Elektoralna 28; 00-892 Warszawa
NIP 525-155-54-94 REGON 012297002

Elektoralna Orthodontics
By Kiworkowa & Brandt Sp.z o.o.
Ul. Elektoralna 28, 00-892 Warszawa
NIP:7010902363 REGON: 382342032

KIWORKOWA DENTAL CLINIC
SPÓŁKA JAWNA
Ul.Elektoralna 28;00-892 Warszawa
NIP:527-268-67-41 REGON:146404945

KIWORKOWA BEAUTY CLINIC
SPÓŁKA JAWNA
Ul. Elektoralna 28; 00-892 Warszawa
NIP: 527-278-36-45 REGON: 365695597

PERMANENT REQUEST TO ACCESS TO MEDICAL/FINANCIAL RECORDS

I request for an access to

□ medical records
□ financial records
□ dental X-rays/ panoramic X-ray/ cephalometric X-ray, tomography

which is held by NZOZ Elektoralna Dental Clinic/ Kiworkowa Dental Clinic Spółka Jawna/Elektoralna Orthodontics by Kiworkowa & Brandt Sp. Z o.o./ Kiworkowa Beauty Clinic Spółka Jawna

The medical documentation refers to a patient: (please fill in if the request is made on behalf of a patient)

……..
NAME AND SURNAME

……..
DATE OF BIRTH

Prepared records:

□ I have recieved personally
□ Please send to an email address**……..

I declare that due to the confidentiality and personal data protection, I accept the medical records referred in Article 2 of the Act 1 of 15 April 2011of the medical practice (Journal of Laws 112, item 654 with changes) under the artkule26 , Article 27 and Article 28 of the Act of 6 November 2008 on the Rights of the patient and the Commissioner for patients' Rights (Journal of Laws of 2009, number 52, item417 with amendments), and that I will cover the full cost of preparation of documentation mentioned above according to the set method of internal records of the Law on patient Rights and the Commissioner for the patient's rights.

……..
Patients/patients representative readable signature

REQUEST RECIEVING CONFORMATION

…….
REQUEST RECIEVEMANT DATE

……..
EMPLOYEE SIGNATURE

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge receipt of photocopies / extract / copy / electronic media *

medical records on:……

…… ……
employee's signature signature of patient / person authorized by the patient /legal representative *

*delete as appropriate
**only if request id filled by patient or person authorized to receive medical records