huisartsen schiphol e.o.

Request form medical records

Patient information

Surname and initials

Maiden name

Date of birth

Address

Postcode

City

Telephone

E-mail

Only fill in undermentioned when the applicant is another person then the patient (only allowed with children younger then 16 years, dementia patients and those mentally not competent).

Applicant name

Relation to patient

Address

Postcode

City

Telephone

E-mail

Requests:

☐ insight in medical records

☐ copy from medical records

☐ correction of objective data in medical records

☐ destruction of medical data from medical records

The figures relate to the treatment with (GP, practice nurs, etc.):

Treatment took place in the periode(s):

If the requests only concerns specific date, which are they?

Sending

The copy can only be handed to the patient/applicant in person.

Signature patient/applicant (strikethrough what does not apply).

City

Date

Signature

Registration number ID

Please sign the form and hand it over at the practice in person and dont forget to bring your ID.