Authorization for a copy of medical and/or nursing file

Undersigned

Name	
Date of birth	
Address	
Postal code / city	
Telephone number	
E-mail	
Reason request	
Which data	
- Specialism(s)	
- Operation data	
- Other (e.g. pictures)	
- X-ray pictures	A CD-Rom can be obtained at the Radiology department, route 375, 1st floor

1. Undersigned hereby authorizes Bureau Patiëntenbelangen of the Catharina Ziekenhuis to request a copy from my personal medical record at one or more specialisms and to provide it to him / her.
2. The Bureau Patiëntenbelangen sends the medical file only by secure e-mail.
3. Undersigned makes a one-off request for a copy and there are no costs involved.

Signature .....

Date .....

Please send this request form, together with a copy of your valid identification to:
Catharina Ziekenhuis, t.a.v. Bureau Patiëntenbelangen, Antwoordnummer 298, 5600 VC Eindhoven
(no stamp is required) or mail it to infopbe@catharinaziekenhuis.nl
Please note that without a copy of your i.d. your request will not be taken care of.

Verification i.d.:
Passport/ I.d.-card/Drivers license/ expiry date .....(to be filled in by Bureau Patiëntenbelangen)