



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)

- Admission data¹

- 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)

¹ State the period of admission