…… ……

(departament) (date)

I, : ……

(name)

PESEL: ……

(PESEL / date of birth)

possessing the ID no.: ……

(ID number)

hereby grant: ……

(name)

possessing the ID no. ……

(ID number)

for collected a medical records:

☐ my own

☐ my minor child ……

(child's name)

……

(type of record)

……

(legible signature of the patient / patient's legal representive)

To be completed by an employee.

I confirm the authenticity of the signature made in my presence.

……

(date and legible signature of the employee)

*delete as appropriate

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