

.....
(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 representative)

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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