**AUTHORISATIONFORM COPY MEDICAL RECORDS.**

As a patient, you can use this form to authorise someone to retrieve your medical records.

Patient surname and initials:_____M/F

Patient date of birth: _____

Patient address:_____

Patient telephone number:_____E-mail:_____

**On my behalf I authorise:**

Surname and initials:_____M/F

Relationship to patient:_____

Current address:_____

E-mail:_____

**To retrieve a copy of my medical records at the hospital (ETZ).**

I will retrieve the medical records at the hospital, ETZ in Tilburg.
Copies of our valid IDs have been added to the request.

Location: _____

Name: _____

Date: _____

Location: _____

Name: _____

Date: _____

Patient signature:

…….

Authorised representative signature:

……..