Borsod-Abaúj-Zemplén
Vármegyei Központi Kórház
és Egyetemi Oktatókórház

CENTRAL HOSPITAL AND UNIVERSITY TEACHING HOSPITAL
OF BORSOD-ABAÚJ-ZEMPLÉN COUNTY

DIRECTOR GENERAL
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Tel: (46) 515-205, Fax: (46) 323-694
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MEDICAL DOCUMENTATION REQUEST FORM

1. Patient's details (person receiving care):

Name: .....

Name at birth: .....

Place and date of birth: .....

Mother's name: .....

Social security number: .....

Address: .....

2. Data requester's (applicant) details:

Name: .....

Place and date of birth: .....

Mother's name: .....

Address/Mailing address: .....

Phone number: .....

E-mail address: .....

3. If you are not requesting the documentation for yourself, you will need to fill in additional information (you will need to attach a power of attorney):

In the case of spouse, direct ascendants/relatives, brother, sister, partner, legal representative, the following data are needed:
Proof of relationship/description of degree of kinship:

Name and serial number of supporting documents:

a.) identity card: .....

b.) birth certificate: .....

c.) marriage certificate: .....

d.) death certificate: .....

e.) declaration of partnership: .....

f.) a document proving your capacity as heir: .....

g.) decision appointing the caretaker: .....

Short reason for the request:

.....

In the case of documentation of a deceased patient, the following data: proof of relationship/description of degree of kinship:
Name and serial number of supporting documents:

a.) identity card: .....

b.) birth certificate: .....

c.) marriage certificate: .....

d.) death certificate: .....

e.) declaration of partnership: .....

f.) a document proving your capacity as heir: .....

g.) decision appointing the caretaker: .....

For the request to be valid, a written authorization from the patient is required when requesting a medical record **during the patient's care,** or a power of attorney in the form of a fully authenticated document from the patient for requesting a medical record **after the end of the care**. The authorization or the power of attorney MUST BE ATTACHED TO THE REQUEST

4. Details of the requested medical documentation:

4.1. Place and time of issue:
Institute (description of member hospital): ....
Ward/department: .....
Date/time: .....

4.2. Scope and type of copy of the requested documentation (the relevant part should be marked with an x).

4.2.1. Full medical documentation ☐

4.2.2. Incomplete medical documentation ☐

4.2.3. In particular:

- Final report ☐
- Outpatient treatment report ☐
- Autopsy report ☐
- Care documentation ☐
- Operational description ☐
- Description of the hour and minute of birth ☐
- Diagnostic imaging findings or ☐
- Diagnostic imaging recording - on CD/DVD ☐

Description: .....

Other documents: .....

5. How to obtain a copy of the medical record
(the relevant part should be marked with an x):

Received in person ☐

Sending by post ☐

Postal address: .....

Other remarks: .....

By submitting the request form, the applicant acknowledges the following:
In accordance with paragraph (5) of Article 12 and paragraph (3) of Article 15 of the General Data Protection Regulation, the first copy shall be provided free of charge. For each additional copy of personal data subject to processing as defined in paragraph (3) of Article 15 of Regulation (EU) 2016/679 of the European Parliament and of the Council (hereinafter the General Data Protection Regulation), the data subject shall pay a fee based on the cost elements set out in a ministerial regulation.
If the copy is sent by post, the postal charges are to be paid by the data requester/applicant.

Dated: ....
Applicant's signature
identity card number

I have checked, I authorise the release of the documentation: .....
Medical Director

Date of issue: ....
Signature of recipient / place and date of birth

Amount to be paid at the cashdesk: ..... Ft.

ie: ..... forint.

.....
signature of administrator