**Request form inspection, copy, correction or destruction OF medical data**

**Patient data**

|  |  |
| --- | --- |
| Surname and initials: |  |
| Maiden name: |  |
| Date of birth: |  |
| Address: |  |
| Postal Code and City: |  |
| Telephone (private or mobile): |  |
| Email Address: |  |

***Fill out below only if the Applicant is another person than the patient (This is Only allowed in children under 16 years old):***

|  |  |
| --- | --- |
| *Applicant Name:* |  |
| *Relationship to Patient:* |  |
| *Address:* |  |
| *Postal Code and City:* |  |
| *Telephone (private or mobile):* |  |
| *Email Address:* |  |

**Request for:**

* Inspection Medical Dossier
* Copy from/from medical file
* Correction of the objective data in the medical file
* Destruction of medical data from the medical record

It concerns treatment data (GP, Practice supporter, etc.):

……………………………………..

Treatment took place in the period:..................................................................................................................................

If the request certain data, what information is it?

.............................................................................................................................................

**Shipping:**

The copy will be sent to you by e-mail. In consultation it can also be picked up.

Signature of patient/applicant (delete if not applicable):

Place:......................... Date:..................................

Signature............................................................................................................................

Registration number ID:.............................................................

**We ask you to bring the application form yourself to the practice with proof of identity us so that we can verify your identity.**