



GREEK REPUBLIC
MINISTRY OF HEALTH

6th HEALTH REGION OF PELOPONNESE, IONIAN ISLANDS, EPIRUS, AND WESTERN GREECE

GENERAL HOSPITAL OF KERKYRA (CORFU)

Application for (select appropriate box) **Medical Report** **copy of Medical Record**

Section 1: Particulars of Applicant (please indicate in the applicant is the patient): <input type="checkbox"/> Yes (please complete Section 1) <input type="checkbox"/> NO (please complete sections 1 and 2)	
SURNAME (English in Block letters) FIRST NAME	
FATHER'S FIRSTNAME AND SURNAME	
INSURANCE NUMBER	ID Patient Card
ID Card No	or Passport No
Contact Address	
mobile phone number	e mail Address
Section 2: Particulars of Patient (to be completed if the applicant is not the Patient) (please refer to paragraph 2 of "Application Notes" for the documents required for the application)	
SURNAME (English in Block letters) FIRST NAME	
FATHER'S FIRSTNAME AND SURNAME	
INSURANCE NUMBER	ID Patient Card
ID Card No	or Passport No
Contact Address	
mobile phone number	e mail Address
Section 3: Details of Medical Report (please select appropriate box) <input type="checkbox"/> Medical Report <input type="checkbox"/> Hospitalization <input type="checkbox"/> Copy of Medical Report <input type="checkbox"/> Lab results <input type="checkbox"/> X Ray results <input type="checkbox"/> Copy from the Emergency Dept Incident Book <input type="checkbox"/> It's about visiting Emergency Dept.	
Period	From To
Section 4: Purpose of Application (please select appropriate box) <input type="checkbox"/> For medical follow up <input type="checkbox"/> For insurance claim <input type="checkbox"/> For personal record <input type="checkbox"/> Others (please specify)	
Section 5: Method of collection (please select appropriate box) <input type="checkbox"/> in person at <input type="checkbox"/> by registered post to: <input type="checkbox"/> applicant's contact address (same address as section 1 indicated) <input type="checkbox"/> the following person Recipient Name	
Section 6: Declaration and Consent (please select appropriate box) <input type="checkbox"/> I have read and agreed the aforementioned "Application Notes" <input type="checkbox"/> I declare that the information given in this application is accurate. I by signing this form authorise/have obtained patient's authorisation to General Hospital of Kerkyra (Corfu) to disclose and send the medical report and/or copy of medical record under this application to me/the recipient in section 6 above	
Signature of Applicant/Patient	Date