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

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| **Section 1:** **Particulars of Applicant** (please indicate in the applicant is the patient):☐ Yes (please complete Section 1) ☐ 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) |
| ☐ Medical Report ☐ Hospitalization ☐ Copy of Medical Report ☐ Lab results ☐ X Ray results ☐ Copy from the Emergency Dept Incident Book ☐ It’s about visiting Emergency Dept.  |
| Period  | From  | To |
| **Section 4:** **Purpose of Application** (please select appropriate box) |
| ☐ For medical follow up ☐ For insurance claim ☐ For personal record ☐ Others (please specify)  |
| **Section 5:** **Method of collection**(please select appropriate box) |
| ☐ in person at ☐ by registered post to: ☐ applicant’s contact address (same address as section 1 indicated) ☐ the following person Recipent Name |
| **Section 6:** **Declaration and Consent** (please select appropriate box) |
| ☐ I have read and agreed the aforementioned“Application Notes“☐ 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 recipent in section 6 above |
| **Signature of Applicat/Patient Date** |