**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** | | | |