GREEK REBUBLIC
MINSTRY 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):	
☐ 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**

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