KLINICKÉ CENTRUM ISCARE
ISCARE a.s., Českomoravská 2510/19, 190 00 Praha 9 – Libeň, IČ 61858366
T: +420 234 770 100 / E: iscare@iscare.cz / www.iscare.cz

Application for the provision of an extract from or a copy of medical documentation

Identification of applicant:

Name and surname: .....

Date of birth /birth number (if assigned): .....

Phone/e-mail: .....

Address (for sending an extract or copy of medical documentation): .....

.....

Type and number of proof identity: .....

I request the provision of (mark chosen option ☒): ☐ **an extract** or ☐ **a copy of** medical documentation

☐ kept **about me** or ☐ kept about the **following patient**:

Patient's name and surname: .....

Date of birth /birth number (if assigned): .....

Patient identification number (if assigned): .....

Relationship of applicant to patient: .....

Note that the patient must agree with your request. If the patient has not expressed his/her consent, in advance, in the document entitled "Record of consent of the patient to the provision of information regarding his/her medical condition", which is included in the medical documentation kept about him/her, you must substantiate your request with the consent of the patient, provided with an officially authenticated signature (such consent is not required, for example, for a lawful representative, guardian, foster parent).

I request:

☐ the provision of all medical documentation about me / about the patient specified above, or

☐ the following parts of medical documentation:

.....

.....

I will collect the extract from or copy of medical documentation:

☐ **in person** or ☐ request that it be **sent** by registered post, with delivery to the addressee only, to the address specified above ☐ request to send to the data box ID: .....

☐ I only require to **view** the medical documentation (preferred date to view medical documentation):

.....

If this application for the provision of an extract from or a copy of medical documentation is sent by post, the **signature on the application must be officially authenticated** so that it is proven to the company that the applicant is genuinely an eligible person. The purpose of this measure is to prevent any possible risk of confidential information being communicated or disclosed to an unauthorised person. If the eligible person appears in person, an ISCARE employee will check his/her identity against proof of identity.

An ISCARE employee will hand over the requested extracts from or copies of medical documentation, once they are ready, in person against payment of the costs involved in providing them according to the valid ISCARE price list. If a patient or other eligible person wishes that the requested documentation be sent by post, it will, once all notification has been made, be sent cash-on-delivery at the price of the costs involved in providing such documentation to the address specified in this application (documentation shall only be delivered to the addressee in person).

Signature of the applicant*:

_____ *(place),* _____ *(date):* _____

Identification of the applicant when signing at the medical facility done on behalf of ISCARE by (first name, surname and signature of employee):

****The signature must be officially authenticated, unless the application is delivered by the applicant in person.***

Address to which the application should be sent: sekretariát, ISCARE a.s., Českomoravská 2510/19, Libeň, 190 00 Praha 9, Czech Republic

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Record of handing over an extract or copy to the applicant:

A copy of (extract from) medical documentation was handed over to the applicant in person on _____
(date)

I confirm with my signature that the data presented above corresponds to fact and that I accepted, in person, the copy of (extract from) medical documentation to the requested extent:

Signature of the applicant:

Signature of the employee who handed the copy of (extract from) medical documentation to the applicant and checked his/her identity: