**REQUEST FORM TO VIEW, COPY, CORRECT OR DELETE MEDICAL DATA**

**Patient’s details**

|  |  |
| --- | --- |
| Surname and initials: |  |
| Maiden name: |  |
| Date of birth: |  |
| Address: |  |
| Postal code and town/city: |  |
| Telephone (home or mobile): |  |
| E-mail address: |  |

***Only complete the section below if the applicant is a different person than the patient (this is only permitted for children under 16 years old):***

|  |  |
| --- | --- |
| *Name of applicant:* |  |
| *Relationship to patient:* |  |
| *Address:* |  |
| *Postal code and town/city:* |  |
| *Telephone (home or mobile):* |  |
| *E-mail address:* |  |

**Request:**

* View medical file
* Copy of/from medical file
* Correction of the objective data in the medical file
* Deletion of medical data from the medical file

This concerns data about the treatment by (GP, nurse practitioner, etc.):

……………………………………..

Treatment was done in the period(s): ........................................................................................

If the request only concerns certain data, which data are they?

...........................................................................................................................................................

**Posting:**

The copy will be sent to you by post. Upon request, it can also be collected.

Signature of patient/applicant (cross out what does not apply):

Place: ......................... Date: ..................................

Signature ............................................................................................................................

Registration number of ID: .............................................................

**We kindly ask you to bring the request form in person to the practice along with your ID so we can verify your identity.**

General practice …

Address: …

Postal code: …

Phone: …

Email: …