KOSOVO SPECIALIST CHAMBERS
DHOMAT E SPECIALIZUARA TË KOSOVËS
SPECIJALIZOVANA VEĆA KOSOVA

Medical Records Authorisation Form

Patient:

Surname: ____________________ First name: ____________________

Date of Birth: ____________________
dd/mm/yyyy

Authorised third-party:

Surname: ____________________ First name: ____________________

Address: ________________ ________________ ____________ ____________________
street & no. city postcode country

Contact: ______________________________ ______________________________
email telephone

Medical records authorised for release

specific type and subject of records (i.e. relating to which medical condition(s)/medical issue(s)):

____

____

over which time period (dates cannot exceed date of request):

from: ______________________________ to: ______________________________
dd/mm/yyyy dd/mm/yyyy

for what purpose (the more information provided, the better your request can be facilitated):

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I confirm that the above named "authorised third-party" may request access to the "medical records authorised for release" as specified above from the Detention Facilities Medical Service. I understand that no records will be released to the authorised third-party until after I have had a consultative process with the Medical Officer to help inform my consent.

Signature of Patient: ________________ Date: ______________