Cichoń
COSMETIC DENTAL CENTRE

13 Borelowskiego-Lelewela St., 30-108 Krakow
Tel: 00 48 12 421 07 43, 00 48 12 294 11 00
info@cichondentalcentre.com
www.cichondentalcentre.com

MEDICAL RECORDS RELEASE AUTHORISATION FORM

1. Place, date: ....
2. Patient's name and surname: ....
3. Residential address: ....
4. ID / Passport / Driving licence *(underline the appropriate)*, number: ....
5. I, the undersigned, authorise the following person to receive my medical records:

   Mr/Ms. ....

   holding ID / Passport / Driving licence *(underline the appropriate)*, number: ....

This authorisation is of a one-off nature.

....

(date and clear signature of patient)

....

(date and clear signature of person receiving authorisation)