BORSOD-ABAÚJ-ZEMPLÉN COUNTY CENTRAL HOSPITAL AND UNIVERSITY TRAINING HOSPITAL
3526 Miskolc, Szentpéteri kapu 72-76.
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HEALTH RECORD REQUEST FORM

1. Patient's details (person who received health care service) [1]:

Name: ....

Birth name: ....

Place & date of birth: ....

Mother's birth name: ....

Social security number: ....

Home address: ....

2. Personal details of the person who requests data [2]:

Name:..

Place & date of birth: ....

Mother's birth name: ....

Home address/Contact address:... ……...

Telephone number:...

Email address: ....

3. Further data to be given in absence of a power of attorney:

3.1 If the requester is a spouse, direct ascendant/descendant, sibling or civil partner then the following details:
Evidence that the persons are related / indication of the degree of relationship:
....
Short reason for this request:
....

3.2. In the case of a deceased patient's documentation, the following details[3]:
Evidence of status as statutory representative, close relative or heir (e.g.: nature and number of document proving the status of heir):
....
....

[1] If the patient who received health care services and the requester are the same person then the details in Sections 2 and 3 need not be completed.

[2] To be completed in each case where the requester requests other health record copy than their own. Except for the entitled persons mentioned in Section 3, the validity of the request shall be supported by a written authorization given by the patient (during their receiving of the health care service) or an authorization given by the patient in the form of a private document of full probative value (after completion of the health care service), and such respective authorization SHALL BE ATTACHED TO THE REQUEST. If the data subject made more statements than the person empowered by the latest statement shall be entitled to act.

[3] In case of death of the data subject, their statutory representative, close relative and heir are entitled – upon their written request – to have access to health data which relates or may be related to the cause of death as well as data related to medical treatment preceding the occurrence of death, to inspect health records, and to receive copies of such health records at the requester's cost.

4. Data related to the requested health record:

4.1. Place and time of origin of the health record:
Institution (designation of member hospital): ....
Department:..
Date/Time:..

4.2. Scope and type of the requested health record copy (mark with a cross as applicable).

4.1.1. Complete health record ☐
4.1.2. Incomplete health record ☐
4.1.3. Within that:
- Hospital discharge note ☐
- Outpatient care slip ☐
- Autopsy report ☐
- Nursing documentation ☐
- Description of surgical operation ☐
- Description relating to time (hour and minute) of birth ☐
- Diagnostic imaging findings, or ☐
- Diagnostic imaging scans - on CD/DVD ☐

Designation: ....

Other record: ....

5. Method of delivery of the requested health record copy (mark with a cross as applicable):

Personal delivery ☐
Delivery by mail ☐
Mailing address:..
Other note:
....

As regards submission of the request, the requester acknowledges the following:
Pursuant to Article 12(5) and Article 15(3) of the GDPR, the health record copy shall be provided free of charge on the first occasion. For any further copies of the personal data defined in Article 15(3) of Regulation (EU) 2016/679 of the European Parliament and of the Council (hereinafter: General Data Protection Regulation) and subject to data processing, the data subject shall pay a fee to be charged on the basis of cost elements determined by the relevant ministerial decree. If the copy is delivered by mail then the mailing costs shall be covered by the requester.

Date: ....
Requester's signature

I have checked and permit the release of the health record..
Medical Director

Date: ....
Recipient's signature / place & date of birth

Amount payable at the cash desk: HUF ....

(in letters): HUF ....

....
signature of registrar / administrator