SWIJGMAN
huisartsenpraktijk

FORM TO REQUEST INSPECTION, A COPY, CORRECTION OR ERASURE OF MEDICAL DATA

Patient data

Surname and initials	
Maiden name (if applicable):	
Date of birth:	
Address:	
Postal code and city:	
Telephone (home or mobile):	
Email address:	

Only to be filled in if the person submitting the request is not the patient (this is only permitted for patients under the age of 16 years):

Name person submitting the request:	
Relation to patient:	
Address:	
Postal code and city:	
Telephone (home or mobile):	
Email address:	

I request to:

☐ Inspect the medical record

☐ Receive a copy of / from the medical record

☐ Correct objective data in the medical record

☐ Erase medical data from the medical record

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It concerns data with respect to the treatment provided by (GP, practice nurse, etc.):

……..

The treatment took place in the following period or periods:
.....

If this request concerns specific data, which data does it concern?

.....

If you request a copy:

The copy will be sent to you by post. If preferred, you can also collect it in person by appointment.

Signature of the patient/person submitting the request (delete as applicable):

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

Signature: .....

ID registration number: .....

Please submit this request form in person at the GP's office and bring your ID so we can verify your identity.

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Kapoenstraat 23
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