MICRODIAGNOSTICS
PRIVATE CYTO/HISTOPATHOLOGY LAB

Request form to provide access to personal medical data

Please fill in all the necessary fields so that we may locate the patient report/s for which the request form is being submitted. Based on the provided data, we will attempt to locate the laboratory results that you require.

The NECESSARY fields are marked with *

1. Patient personal Information	Name/Surname*:_____ Other names (abbreviations, alternative spelling, previous name etc):_____ Date of birth*:_____ Phone Number:_____ Address*:_____ _____ AMKA:_____ Private Insurance:_____

2. Examination Information	Name of referring Doctor or of medical center*: _____ Address of above*:_____ _____ (approximate) Date when laboratory services were requested DD/MM/YY*:_____ Phone number of referring doctor or medical center:_____

3. Authorization	I, the undersigned, request that MICRODIAGNOSTICS conducts a search in their files and provides either to myself or to the person indicated in Table 4 a copy of the patient report/s. NOTE: If you are a legal representative of the patient, you have to provide some form of proof of representation (medical authorization, court order, power of attorney etc) Name and surname*:_____ Relation to the patient*: (pick one) ☐Myself ☐ Parent ☐ Guardian (proof necessary) ☐ Legal Representative (proof necessary) Signature*:_____ Date*:_____

4. Delivery	Deliver to (Name and Surname)*:_____ Address (if different than the one provided before):_____ _____ OR Fax:_____ OR e-mail:_____

Please submit the completed application (along with the proof of representation if applicable) to the following address:

MICRODIAGNOSTICS – I.D.HATZIBOUGIAS Ltd, Mitropoleos 88, PO 54622, Thessaloniki

Or Fax at +302310 232272

MICRODIAGNOSTICS is bound to respond within 30 days from the request.