

### Request for Medical Records

Surname: \_\_\_\_\_

First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### Release from the Duty of Confidentiality

\_\_\_\_\_ (Surname and first name in block letters)

hereby consent to all my medical reports and records being forwarded to

#### Practice of Dr Jan Kader

Kirchweg 7  
47652 Weeze  
Telephone 02837 / 2500

This includes all medical reports and documents accumulated throughout the entire course of my treatment at your practice.

I hereby release the practice \_\_\_\_\_

from its duty of medical confidentiality with regard to the disclosure of medical reports, findings and information.

\_\_\_\_\_  
Signature

(Original document available)