

Procedure for requesting medical records

The Nederlandse Obesitas Kliniek is obliged to keep medical records for every patient.

As a patient you are entitled to access your medical records. Access is granted by means of a copy. Moreover, you are entitled to correction, supplementation or deletion of your medical records. Nobody, except yourself, has any rights to your medical records, unless you have given written permission.

You are the patient

Follow the procedure below if you wish to implement your right to copy, correction, supplementation or deletion of your medical records.

You are not the patient

Follow the procedure below to request the medical records of someone else. In addition to your signature, the patient must also sign the request form. In doing so, the patient gives the requester permission to access their medical records. This does not apply to patients who are unable to decide for themselves (legally incapable) or deceased patients.

Procedure:

- Complete the request form in full.
- Send or e-mail the form, including a copy of a proof of identity, to the relevant NOK location.
- You will receive a confirmation as soon as we have received your request. A copy of the request form will be stored in your records.
- The doctor will review your request. If the request cannot be implemented, we will discuss this with you by phone.
- Processing the request
 - **Copy:** a copy of your records will be e-mailed to you via ZorgMail within three working days. The e-mail address supplied on the request form will be used to do so.
 - **Correction/supplementation/deletion:** once approved, your request will be implemented as soon as possible.

Costs:

There is no charge for requesting your medical records.

Medical records request form

Complete this form in full and include a copy of the patient's and the requester's proof of identity. Incomplete requests will not be considered.

Patient details

Name and initials:
Date of birth:
Address:
Postal code and town/city:
E-mail address:
Mobile telephone number:

Requester details

(if you submit a request on behalf of the above patient)

Name and initials:
Address:
Postal code and town/city:
E-mail address:
Mobile telephone number:
Relationship to the patient:

Request for:

☐

Copy of the medical records via e-mail

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Correction/supplementation/deletion of the medical records

Explanation of the request:
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The patient/requester hereby declares to be informed about the procedure for requesting the medical records.

Date:

Signature of the patient:

Signature of the requester:

To be completed by the Nederlandse Obesitas Kliniek

Date of receipt: