LUXDENTICA

CENTRUM STOMATOLOGII

PATIENT'S DECLARATION OF AUTHORISATION / REFUSAL TO AUTHORIZE THE ACCESS TO INFORMATION / MEDICAL RECORDS IN LUXDENTICA DENTAL CENTER

I, the undersigned PESEL / Date of birth

*for persons without PESEL number: date of birth

**names and surname of the child/ incapacitated person _____

**PESEL number of a child/incapacitated person(for newborn baby- mother's PESEL number) _____

☐ I do not authorize anyone to obtain information about my health condition.

☐ I do not authorize anyone to obtain my medical records.

☐ I hereby authorize:

Mr/Mrs PESEL number/date of birth

I provide contact of the authorized person (telephone number/ email) _____

☐ to receive information about my health and health care.

☐ to obtain my medical records.

☐ to arrange, modify, cancel visits and receive information about planned and completed visits.

PATIENT CONSENT

☐ I agree to arrange, change, cancel and remind me about appointments by phone.

☐ I agree to arrange, change, cancel and remind me about appointments via email.

☐ I agree to arrange, change, cancel and remind me about appointments by WhatsApp.

☐ I consent to receiving commercial information via email as per law from the 18th of July 2002.

☐ I consent to the use of my telecommunications equipment for marketing purposes as per art172 from 16th of July 2004 Telecommunication law.

☐ I consent to external and internal photographs being taken and added to my medical records.

☐ I consent to the processing of the personal data provided above in accordance with the content of Regulation 2016/679 of the European Parliament and Council EU of 27th April 2016 on the protection of individuals with regard to the Processing of Personal Data and on the free movement of such data repealing directives 95/46/WE (General Data Protection Regulation - RODO) for the implementation of this authorization and for providing healthcare services.

_____

Date and signature

*circle the appropriate one **complete if applicable