**MEDICAL UNIVERSITY OF BIALYSTOK**

**CLINICAL HOSPITAL**

**UNIVERSITY GENERAL PRACTITIONER**

ul. Waszyngtona 15A, 15-274 Białystok

tel. 85 831 89 50

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Nr. Księgi Rejestrowej 000000018587

Gab. lek. ROZ kod res. V-11, Vll-181, Vlll-0010

NFZ: 10-00-00068-18-103-01/13

STATEMENT

First and last name: PESEL:

Address:

Based on the regulation of the Minister of Health of 21 December 2010 on the types and scope of medical documentation and the method of its processing (art. 30 section1 of the Act of 6 November 2008 on patient rights and the Patient Ombudsman, Journal of Laws of 2009, no. 52, item 417 and no. 76, item 641 and of 2010, no. 96, item 620)

I, the undersigned, declare that I AUTHORIZE

Personal data (Name, Surname, PESEL), address, telephone:

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……………………………………………………………………………………………………………………..

* to obtain information about my health condition and any health services provided to me, including diagnosis, treatment and complications;
* to obtain medical records related to me.
* to collect prescriptions

I agree to have my personal data processed.

* I, the undersigned, **DO NOT GIVE MY CONSENT** AND I **DO NOT AUTHORIZE** anyone to obtain my medical records or obtain information about my health condition and services provided to me.

I agree to have my personal data processed.

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date and legible signature of the insured person