FEBUMED.

PATIENT REGISTRATION FORM FOR ADULTS

PERSONAL DATA

Name _____ Surname _____

Sex ☐ F ☐ M Date of birth ☐☐-☐☐-☐☐☐☐ PESEL ☐☐☐☐☐☐☐☐☐☐☐

If you have no Polish personal identification number PESEL:

Passport series and number _____ Nationality (Country) _____

ADDRESS AND CONTACT DETAILS

Address of residence in Poland ☐ No address of residence in Poland

Street _____ Building number _____ Flat number_____

Postal code _____ Town / City _____

Phone number (+48) _____

Email address _____

FEBUMED Sp. z o.o. with its registered office in Warsaw at ul. Zygmunta Modzelewskiego 77 (02-679 Warszawa), entered in the register of entrepreneurs kept by the District Court for the Capital City of Warsaw in Warsaw under KRS number 0000962300, as data controller, informs you that your personal data – to the extent provided in the new patient registration form – are collected for the purpose of providing medical services.
You have the right to review and update the content of these data. The provision of data is voluntary, but the data are necessary for the proper performance of the services.

I hereby give my consent to FEBUMED Sp. z o.o. to send me information (confirmation, cancellation, rescheduling) about planned medical appointments, examinations, and treatments by means of electronic communication (via email and/or phone, also via text messages – only to a Polish phone number).

☐ **I hereby consent** ☐ **I hereby do not consent** to sending the results of my examinations and/or my medical records electronically to **the email address** indicated above.

I declare that I have been informed that my personal data will be processed by FEBUMED sp. z o. o., in accordance with the information clause for FEBUMED patients provided to me in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC, hereinafter referred to as: "GDPR". The text of the clause is available at the reception desks of FEBUMED medical facilities and online at: www.febumed.pl/polityka-prywatnosci

☐☐-☐☐-☐☐☐☐ _____

Date of signature Legible signature of the patient

FEBUMED.

Name and surname: _____ **PESEL** ☐☐☐☐☐☐☐☐☐☐☐

MARKETING CONSENTS

☐**I hereby consent** ☐ **I hereby do not consent** to the processing of the **phone number** I have indicated above for marketing purposes, including to inform me of new products/services and promotions from FEBUMED.

☐**I hereby consent** ☐ **I hereby do not consent** to the processing of the **email address** I have indicated above for marketing purposes, including to inform me of new products/services and promotions from FEBUMED.

☐☐-☐☐-☐☐☐☐ _____

Date of signature | Legible signature of the patient

AUTHORISATION TO ACCESS / COLLECT MEDICAL DOCUMENTATION

1. To obtain information about my health condition and the health services provided, in accordance with Article 9(3) of the Act of 6 November 2008 on Patients' Rights and Patients' Rights Ombudsman (i.e. Journal of Laws 2019, item 1127, as amended):

☐ **I do not authorise anyone**

☐ **I authorise**_____

(Name and surname of the authorised person)

Date of birth of the authorised person ☐☐-☐☐-☐☐☐☐

2. To have access to my medical records in accordance with Article 26(1) of the Act of 6 November 2008 on Patients' Rights and Patients' Rights Ombudsman (i.e. Journal of Laws 2019, item 1127, as amended) (in particular: test results, prescriptions, results of consultations)

☐ **I do not authorise anyone**

☐ **I authorise**_____

(Name and surname of the authorised person)

Date of birth of the authorised person ☐☐-☐☐-☐☐☐☐

3. Being aware that, in accordance with the provisions of the above-mentioned Act, after the death of a patient, medical records shall be made available to a person authorised by the patient during his or her lifetime, as well as to the person's relatives, unless the release is opposed by the patient, I hereby declare that:

☐ **I do not authorise anyone** to have access to the medical records after my death

☐ **I uphold the authorisation** to those authorised during my lifetime, as well as to my relatives

I hereby declare that I have been informed of the possibility of withdrawing the consents and authorisations given.

☐☐-☐☐-☐☐☐☐ _____

Date of signature | Legible signature of the patient

TO BE FILLED IN BY THE FEBUMED EMPLOYEE

I declare that the signatures affixed in my presence are authentic

_____ (Date of employee's signature)

_____ (Legible signature of the employee)