KOPERNIK	**The Nicolaus Copernicus Provincial Multispecialty Center for Oncology and Traumatology in Łódź** Łódź 93-513, ul. Pabianicka 62, Identification code of the Center: 000000004373
	STATEMENTS* – PATIENT'S CONSENT FOR ADMISSION TO THE HOSPITAL

Date……..

Patient's full name	**PESEL**
Name and surname of parent / legal guardian *(applies to patients under 18 years of age)*	
Residential address:	**Phone number**
Mailing address *(if different from residential address)*	**Email address**

☐ **I consent to treatment and stay in the Hospital.**

☐ **I do not consent to treatment and stay in the Hospital.**
I have been informed of the potential adverse consequences of refusing treatment and stay in the Hospital for my health and life / for the health and life of my child*.**

To ensure safety during the provision of medical services, your first and last name, as well as your date of birth, will be placed on the identification band. If you do not consent to having your first name, last name, and date of birth on the external side of the band, they will remain on the inner side.

☐ **I consent** to having my first name, last name, and date of birth placed on the external side of the identification band.

☐ **I do not consent** to having my first name, last name, and date of birth placed on the external side of the identification band.

……..……
*Legible signature of the patient/ legal guardian****

……..……
*Legible signature of the child over 16 years of age ***

☐ **I authorize:**

1. Ms./Mrs. ……

Residing in …….. Street …….. No. …, Phone ……

2. Ms./Mrs. ……

Residing in …….. Street…….. No. …, Phone. ……

to receive information about my / my child's* health condition and medical services provided.**

☐ **I do not authorize** anyone to receive information about my / my child's*** health condition and medical services provided.

☐ **I object** ☐ **I do not object** to disclosing information about my / my child's*** health to a close relative after my / my child's*** death.

☐ **I authorize:**

1. Ms./Mrs. ……

Residing in …….. Street…….. No. …, Phone ……

2. Ms./Mrs. ……

Residing in …….. Street…….. No. …, Phone. ……

to access my / my child's* medical records.**

☐ **I do not authorize** anyone to access my medical records.

☐ **I object** ☐ **I do not object to** providing my / my child's*** medical records to a close relative after my/my child's*** death.

……..……
*Legible signature of the patient/ legal guardian****

……..……
*Legible signature of the child over 16 years of age ***

INFORMATION CLAUSE

In order to ensure transparency in the processing of personal data in connection with the provision of medical services, we would like to inform you that:

Data of the Personal Data Administrator:

- The Administrator of your personal data is the Nicolaus Copernicus Provincial Multispecialty Center for Oncology and Traumatology in Łódź, hereinafter referred to as the Hospital.
- Contact details of the Hospital: 93-513 Łódź, ul. Pabianicka 62, Phone: +48 42689 5000, E-mail: szpital@kopernik.lodz.pl.
- If you have any questions regarding the processing of data, please address them in writing to the Hospital or by email to the Data Protection Officer, Mr. Tomasz Zdzienicki (iod@kopernik.lodz.pl).

Purpose of Data Processing

We process your data in connection with the provision of healthcare services.

Full Information on the Processing of Personal Data

You can obtain the full information at registration points, healthcare service locations, and on the Copernicus Hospital in Łódź website at the following E-mail *www.kopernik.lodz.pl*

Additionally:

1. You have the right to deposit valuable items.
2. The Hospital is not responsible for items that are not deposited and/or stored in the clothing storage.
3. You are obligated to promptly retrieve your items from the deposit and/or clothing storage after your treatment is completed.
4. Smoking, alcohol consumption, and the use of intoxicating substances, as well as the possession of sharp objects, firearms, and any dangerous items, are strictly prohibited on the hospital premises.
5. You have the right to change the authorized person(s) above.***

……..……

Legible signature of the patient/ legal guardian ***

……..……

*Legible signature of the child over 16 years of age***

NOTICE! Fill only in the case of revoking previously granted authorizations!!!

I hereby revoke the above mentioned authorization(s) with affect from …… .****

……..……

*Legible signature of the patient/ legal guardian****

……..……

*Legible signature of the child over 16 years of age***

Legend:

*Statements - Only the patient or their legal guardian may complete the consent form for admission to the Hospital.

** If the patient is over 16 but under 18, the information should be duplicated, addressed to both the patient and their legal guardian.

*** ---------- Delete as unnecessary.

**** In the event of revoking the mentioned authorizations, this statement becomes invalid, and the patient completes new statements according to their will.

☐ - Place an "X" in the appropriate space.

Close Relative - spouse, relatives up to the second degree, in-laws up to the second degree in a direct line, legal representative, cohabiting partner, or a person designated by the patient