



**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 OUTPATIENT CLINIC**

Date.....

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

**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 \*\**

**I authorize:**  
 1. Ms./Mrs. ....  
 Residing in ..... Street..... No. ..., Phone .....

**to collect prescriptions and/or orders for medical supplies necessary for the continuation of treatment and/or medical supply provision.**

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

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

**or**

I declare that prescriptions and/or orders for medical supplies necessary for the continuation of treatment and/or medical supply provision can be collected by third parties without specifying those individuals.

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

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



**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 Zdzenicki (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](mailto:www.kopernik.lodz.pl)

Additionally:

1. 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.
2. 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