AUTHORIZATION OF PERSONS ENTITLED
TO RECEIVE INFORMATION ABOUT MY HEALTH STATUS

HEALTHCARE SERVICE PROVIDER

Provider name: **SPINEZIO s.r.o.**

Company ID (IČO): **07206241**

Registered office: Sokolovská 444/118, Karlín, 186 00 Prague 8

This document serves to confirm your rights under Act No. 372/2011 Coll., on Health Services, and other applicable legal regulations.

PATIENT AUTHORIZATION

I have been informed about my right to authorize persons who may be informed about my health status.

These persons may:

- receive information about my health status,
- receive the scope of information that may be provided to these persons,
- be authorized to access my medical records,
- be authorized to collect extracts, copies or summaries from my medical documentation,
- be authorized to collect results of healthcare services in cases provided for by applicable legal regulations.

I am currently informed of my right to:

- revoke authorization for providing information about my health status to any person at any time,
- cancel or change the scope of persons who may be informed,
- submit a written request to change or revoke this authorization.

AUTHORIZATION OF PERSONS ENTITLED TO INFORMATION ABOUT MY HEALTH STATUS

Full name and surname	Date of birth	Relationship to patient	Scope of authorization (please tick)
			☐ information about health status ☐ access to documentation ☐ copies of documents ☐ authorization to collect results
			☐ information about health status ☐ access to documentation ☐ copies of documents ☐ authorization to collect results

PROHIBITION OF PROVIDING INFORMATION

☐ I do not wish any information about my health status to be provided to any persons.

REFUSAL TO PROVIDE INFORMATION

☐ I do not wish any information about my health status to be provided.

Please note that in cases defined by applicable legal regulations, information may be provided without your consent for the protection of life or health of you or another person.

PATIENT DECLARATION

I hereby declare that I have been informed of my rights concerning the provision of information about my health status and the processing of my medical documentation.
I have had the opportunity to ask additional questions and receive clear answers to them.

Date: _____ _____

Full name and surname of patient: _____

Date of birth: _____

Patient signature: _____

This document must be included in your medical documentation.
The listed persons, authorization, or submission of a request for change or revocation may be changed or canceled at any time.