PATIENT'S STATEMENT

I, the undersigned,

Patient .....

name and surname *PESEL number (in the absence of a PESEL number, enter the name, series and number of the identity document and the country of issue of the document)*

Address of residence .....

Mailing address .....

Invoicing data.....

name or company name

.....

Address *Tax Identification Number (in the case of a company)*

Statutory Representative patient).....

(if applicable) *name and surname* *PESEL number (in the absence of a PESEL number, enter name, series and number of the identity document and the country of issue of the document)*

I declare that:

1. I hereby give my consent to the medical care provided by **NIEWADA CLINIC IMPLANTOLOGIA I STOMATOLOGIA ESTETYCZNA** with its registered office in Warsaw 02-765, Al. Wilanowska 5 loc.uż, 2 (hereinafter referred to as the "**Clinic"),** under the conditions specified in the applicable law, in the Organizational Regulations of the Clinic[1] and
   in this consent, as well as in the contract for the provision of medical services, if such an agreement is concluded by the Patient with the Clinic.
2. I agree to be contacted by phone and text message from the Clinic to the telephone number provided by me _____ ;
3. • I agree • I do not agree to correspondence to my e-mail address (below), including the sending of test results and other elements of medical records, if I so wish. The documentation will be sent in a hashed file. The password will be sent by text message to the phone number provided above;
   E-mail address *(each character in a separate box):*

4. I have been informed that patients are required to present a photo ID before each visit in order to be properly, in accordance with the law, identified by the Clinic.
5. I am aware of the need to inform the medical staff of the Clinic about my health condition, past treatments, and illnesses. The Clinic is not responsible for complications that are in a cause-and-effect relationship with the patient's failure to provide reliable and true information about his or her health condition;
6. all data contained in this statement are true, I undertake to inform the Clinic about their changes; I am aware of the need to update my contact details on an ongoing basis and the consequences of not doing so - if the Patient does not inform the Clinic about the change of phone number, it may result in sending a text message information about the visit to another, unauthorized person.
7. I have been informed that the Clinic, including dental offices, uses video surveillance;

[1] The Clinic's organizational regulations are available at the Clinic's Reception and on the www.niewadaclinic.pl

8. • I agree • I do not consent to the processing of my personal data in the scope including name, surname, address of residence, e-mail address by NIEWADA CLINIC IMPLANTOLOGY AND AESTHETIC DENTISTRY with its registered office in Warsaw 02-765, al. Wilanowska 5 lok. 2 for marketing purposes.

9. I have been informed that: **a/** The administrator of my personal data is Paweł Niewada running the business of NIEWADA CLINIC IMPLANTOLOGIA I STOMATOLOGIA ESTETYCZNA with its registered office in Warsaw 02-765, al. Wilanowska 5 lok. uż. 2. **b/** The Controller has appointed a Data Protection Officer, contact iod@niewadaclinic.pl **c**/ my data is processed for health purposes d/ I have the right to access the data, to rectify and supplement it, as well as to request restriction of processing, objection to processing, portability - in cases specified by the provisions of the GDPR and the right to lodge a complaint with the President of the Personal Data Protection Office; e/ full information on data processing can be found in the Privacy Policy available at the Clinic and on the website of the www.niewadaclinic.pl

10. AUTHORIZATION*/

• I do not authorize anyone to obtain information about my health condition and the health services provided to me.

• The person authorised to obtain information about my health condition and the health services provided to me is:

_____

Name and surname of the authorized person *Contact phone number*

• I do not authorize anyone to obtain my medical records.

• A person authorised to obtain medical records relating to me in any legal Acceptable forms of sharing medical records are**:**

_____

Name and surname of the authorized person *Contact phone number*

Date and legible signature of the Patient _____

Date and legible signature of the Legal Representative in the case of a minor Patient

_____

In the case of a patient between 16 and 18 years of age - parallel consent of the patient's legal representative*)*

_____

On behalf of the Clinic, I have accepted this document (statement and authorizations) and am at the disposal of the Patient in the scope of any questions. I have established the identity of the Patient on the basis of the identity document presented to me _____

enter the type of identity document

_____

Date and legible signature of the authorized employee of the Clinic

_____

*/ Legal basis:

- Article 26 of the Act of 6 November 2008 on Patients' Rights and the Ombudsman for Patients' Rights (Journal of Laws 2023.1545 consolidated text)
- Art. 8 Regulation of the Minister of Health of 6 April 2020 on the types, scope and templates of medical documentation and the manner of its processing (Journal of Laws 2022.1304, consolidated text)