GRUPA LUXMED

..............................................
*Date and location*

# PATIENT'S STATEMENT TO AUTHORIZE / TO DENY AUTHORIZATION TO ACQUIRE INFORMATION / MEDICAL DOCUMENTATION

Patient's name/names and surname......................................................................................................

PESEL number/ date of birth of the person authorizing..................................................................................

*In case where the person submitting the statement is other than patient ( incapacited person/ minior):

Names and surname of the child/ an incapacited person:.............................................................................

PESEL number/ date of birth:............................................................................................................

## 1. OBTAINING INFORMATION ON HEALTH AND HEALTH BENEFITS PROVIDED TO THE PATIENT

☐ I do not authorize anyone ☐ I authorize:

Mr /Mrs ..............................................................................................................................

PESEL number/ date of birth.........................................................................................................

Contact details (telephone numer / e-mail adress) ..................................................................................

The authorization concerns health services provided by:

☐ all LUX MED facilities

☐ LUX MED facility: ..................................................................................................
(write which facility)

☐ **I am opposed to giving my relatives information about my state of health and the health benefits I have provided after my death**

## 2. ACCESS TO MEDICAL DOCUMENTATION

☐ I do not authorize anyone ☐ I authorize:

Mr /Mrs ..............................................................................................................................

PESEL number/ date of birth.........................................................................................................

Contact details (telephone numer / e-mail adress) ..................................................................................

The authorization concerns health services provided by:

☐ all LUX MED facilities

☐ LUX MED facility: ..................................................................................................
(write which facility)

☐ **I am opposed to access to my medical documentation by my relatives after my death**

..................................................
*Date and signature of the application receiver*

..................................................
*Date and signature of the applicant*

** fill in if applies*
*Legal basis: Patient's Bill of Rights and of Patient's Rights Advocate*