GRUPA LUXMED

.....
Date and location

PATIENT'S STATEMENT TO CANCEL 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. Cancellation of Patient's statement regarding authorization to access to the information about the state of health and health service

Mr /Mrs .....

PESEL number/ date of birth.....

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

The cancellation of the authorization concerns health services provided by:

☐ all LUX MED facilities

☐ LUX MED facility: .....
(write in where the visit took place)

2. Cancellation of the Patient's statement regarding authorization to access to the medical documentation

Mr /Mrs .....

PESEL number/ date of birth .....

Cancellation of authorizations concerns the documentation created in:

☐ all LUX MED facilities

☐ LUX MED facility: .....
(write in where the visit took place)

.....
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