



Cracow,.....

.....  
Patient name

.....  
PESEL/ date of birth

### PATIENT CONSENT FORM

#### AUTHORIZATION TO REALASE INFORMATION TO FAMILY MEMBERS

*Many of our patients allow family members such as their spouse, parents or others to come and request the results of tests and procedures. Under the requirements for RODO, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results or information about your care released to family members you must sign this form. Signing this form will only give consent to release information to the family members indicated below.*

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Gastromedica sp. z o.o. to release my results and reports to the following individuals:**

1. Name:.....Date of birth:.....  
Adress:..... Phone number: .....

2. Name:.....Date of birth:.....  
Adress:..... Phone number: .....

**I do not authorize Gastromedica sp. z o.o. to release my results and reports to anyone.**

.....  
Patient signature