**PATIENT´S CONSENT TO CONSULTING HIS/HER MEDICAL RECORDS, MAKING EXTRACTS OR COPIES THEREOF AND PROVIDING INFORMATION ON HIS/HER STATE OF HEALTH**

I, the undersigned

Degree, first name, surname: .………………………………………………………………..

date of birth: …………….…………………………………………………………………

Permanent address including postal Code:……………………………………………………

**hereby appoint**

 within the meaning of Section 65(1) of Act No. 372/2011 Coll., on Health Services and Conditions of Their Provision, as amended, (hereinafter referred to as the “**AHS**“),

Degree, first name, surname/legal entity name:………………………………………………

date of birth/company ID (Reg.) No.:…………………………………………………………

Permanent address/registered office:……………………………………………………………

as an individual/a legal entity authorised to consult my medical records maintained by the health service provider Nemocnice České Budějovice, a.s., with its registered office at B. Němcové 585/54, 370 01 České Budějovice, company ID (Reg.) No. 260 68 877 (hereinafter referred to as the "**Hospital**"), and to make copies or extracts thereof,

*\* Mark (tick) the option as necessary:*

□ in full

□ limited to:……………………………………………………………………………………..

and I also

**grant my consent**

within the meaning of Section 51(2)(b) of the AHS

to the Hospital and its healthcare personnel to inform the above natural individual/legal entity on the data or any other facts they have learned in relation to the provision of health services and my state of health

*\* Mark (tick) the option as necessary:*

□ in full

□ limited to:……………………………………………………………………………………

In …………………………………….. date:…………….

………………………………………………

**Officially authenticated signature of the Patient**