Healthcare provider:
IMMUNO-FLOW, s.r.o.
U Pazderek 25, 181 00 Praha
Tel.:286 923 150
e-mail: info@immunoflow.cz

Patient	**Legal Representative**
Name/Surname:……..	Name/Surname:……..
Date of birth:……..	Date of birth:……..
Address:……..	Address:……..
Phone:……..	Phone:…….
e-mail:……..	e-mail:…….

List of persons allowed to have access to medical records of the patient and entitled to be informed about the patient's health.

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I, the undersigned, hereby declare, that the listed persons are allowed to consult my medical records, kept by the healthcare provider, and be informed about my health.

PLEASE TICK THE RELEVANT BOX

☐ The patient hereby asks the healthcare provider to send all details from the medical documentation by email on the following email address: **……@……..**
or to be communicated by phone using a password, which is the patient's birth number (if the patient doesn't a Czech birth number then it's the birth date)

The provider informed the patient that the medical reports, laboratory test results and other documents include personal data and specific personal information and will be sent on patient's request to the above listed email address by unsecured electronic channel or communicated by phone based on the above-mentioned password. The provider expressly points out, that this is carried out on patient's request and that the provider is not in any way responsible for faulty or uncomplete delivery or handling of this information.

☐ The patient hereby accepts to be called out by his/her name in the waiting room.

The patient understands and accepts the above information, and confirms with a signature below.

……	…….
In Prague on	patient's signature (legal representative)