1.1. I authorize the following persons to **receiving information** about my health and benefits provided to me:

No.	Authorized person	Address

□ **1.2** I do not authorize anyone to receive information about my health and benefits provided to me

□ **2.1** I authorize the following persons to **obtain medical records** concerning my person

No.	Authorized person	Address

□ **2.2** I do not authorize anyone to obtain medical records regarding my person

Date of submitting the statement: .....

Patient's Signature.....

ul. Polna 3 Warsaw,
tel. +48 22 826 20 64
www.triodent.com.pl

Welcome to Specjalistyczna Klinika Stomatologiczna TRIO-DENT in Warsaw.

We kindly ask you to answer the questions below. Filling in the questionnaire will enable you and your doctor to quickly and systematically collect relevant information. This is necessary to obtain the best cooperation between dentists of various specialties conducting your treatment. It is also important to get acquainted with your general health condition, because both the accompanying and past diseases, age and lifestyle have impact on the course of treatment and its effects. All information provided by you is covered by medical secrecy and is available only to the medical personnel involved in the treatment. We are required to collect and store personal data in accordance with The Patient Rights and Ombudsman Act of November 6, 2008 (Journal of Laws 2009 No 52, item 417) and the articule 9 of Regulation 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data.

.....
PATIENT'S FIRST AND LAST NAME

.....
ADDRESS OF RESIDENCE (street, postal code, city)

Personal Identification Number (PESEL)/DATE OF BIRTH

....
CONTACT TELEPHONE EMAIL ADDRESS