

Patient Consent

First name and surname _____

Date of birth _____

I consent to persons acquiring qualifications for the practice of a healthcare profession having access to my medical records, but only to the extent necessary and on the basis of authorisation granted by the designated healthcare professional.

I consent to the presence of, or, as the case may be, the provision of healthcare services by persons acquiring qualifications for the practice of a healthcare profession during the provision of healthcare services, on the basis of authorisation granted by the designated healthcare professional.

In Prague on

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Signature of patient