

Patient's Consent

MAGNETICKÁ REZONANCE



Health Services Provider:

Název: Klinika JL-MR, s.r.o.

Sídlo: V hůrkách 1296/10, Praha 5, 158 00
(hereinafter "the Provider")

Patient:

Name and surname: _____

Date of birth: _____ **Phone No.:** _____

Address: _____

(hereinafter "the Patient")

The Patient expressly asks the Provider to send all information about the Patient's health Condition via an unsecured electronic channel to his/her **email address:**

(Kindly specify in block letters)

The Provider has informed the Patient that in connection with health services providing the medical reports, laboratory results and other outcomes and documents include personal data and special personal data of the Patient, which shall be sent at the Patient's request to the above-specified Patient's email address via an unsecured electronic channel. The Provider expressly notifies the Patient that it shall proceed in the above-specified manner at the Patient's request, and that it shall bear no responsibility for potential erroneous, incomplete, or Otherwise undesirable delivery or handling of such information. The Patient understands the provided information, takes it into account, and still asks that such information be sent to the above-specified email address, which he/she confirms with his/her signature. The Patient is aware of the fact, that email communication is not intended for ordering of services offered by the Provider, and agrees that this arrangement shall constitute part of his/her medical documentation.

In Prague on: _____

Patient signature: _____

Stamp of the clinic:
(Provider)