

**SPORT MEDICA S.A.** NZOZ CAROLINA MEDICAL CENTER

ul. Pory 78, 02-757 Warszawa Nr ks. rejestrowej 000000024799 tel. (22) 355 82 00, fax (22) 355 82 10 cmc@carolina.pl, www.carolina.pl REGON 016291775

## Patient registration form

Patient registration form	Patient ID
(1) Personal data	
First name  Sex Female Male Date of birth — — Other (give name)  Series / number of the document Citizenshi	PESEL PESEL
Provincial branch of the NFZ (if applicable)	
(2) Contact details	
Address of residence	
Street City / town	House No Flat No Country
Mailing address (if different from above)	
Street City / town	House No Flat No Country
Contact details  Cell phone No	dome phone No
E-mail address	
(3) Sports	
Discipline's name Amate	eurishly High- performance Professionally
Discipline's name Amate	eurishly High- performance Professionally
Payer (ie. Insurance company if applicable)	
Payer's name	Payer's tax No
Street	House No Flat No
Zip code City	Country
Pursuant to Article 24 of the Personal Data Protection Law of 29 August 1997 (Journal of Laws of 2014, item 1182, as amended), Sport Medica S.A. with its registered office in Warsaw at ul. Pory 78 (02-757 Warszawa), being the data administrator, hereby informs you that the personal data - to the extent provided in the patient registration card - are collected in order to provide medical services.	Date
You have the right to access the contents of these data and update them. The data are provided voluntarily, but they are necessary to provide a service in a proper way.  * I give my consent for Sport Medica S.A.to send me, by electronic means of communication (e-mail) and/or telephone, including short text messages) information on the planned appointments with doctors, medical examinations and procedures.	Signature of the person who submits the declaration (legible)
* I agree to have my personal data included in this form, i.e. only the name, surname, date of birth, telephone and e-mail address, processed for marketing purposes, as well as offering and selling services and products by:	
* Sport Medica S.A. with its registered office in Warsaw, ul. Pory 78.	Date
* LUX MED sp. z o.o. with its registered office in Warsaw ul. Postępu 21C.  * I give my consent for Sport Medica S.A. and/or LUX MED. sp. z o.o. to send me commercial information by electronic means pursuant to the Act on Rendering Electronic Services of 18 July 2002 (Journal of Laws of 2002, No. 144, item 1204, as amended).  I declare that pursuant to the Personal Data Protection Act (Journal of Laws of 2014, item 1182, as amended) I have been informed that provision of the data for marketing purposes is voluntary, that I have the right to access the contents of these data and update them, about the right to request in writing for discontinuation of their use for marketing purposes, as well as the objection, to which I am entitled with respect to each of the above-mentioned entities.	Signature of the person who submits the declaration (legible)



## SPORT MEDICA S.A.

NZOZ CAROLINA MEDICAL CENTER ul. Pory 78, 02-757 Warszawa Nr ks. rejestrowej 000000024799 tel. (22) 355 82 00, fax (22) 355 82 10 cmc@carolina.pl, www.carolina.pl REGON 016291775

## Patient's statement of authorization / denial of authorization to obtain information / medical records

I, the undersigned Name Surname Holder of ID card* Passport* Series Number  PESEL (Polish Resident Identification Number)** Onlid of birth — — — — — — — — — — — — — — — — — — —	Patient*	Leg	gal guar	alali/10	present	tative															
PESEL (Polish Resident Identification Number)  Name and sumame of child**  Child PESEL (Polish Resident Identification Number)**  I state that to obtain information on my / my child's* state of health and health services:  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Sumame  Holder of ID card*  Passport*  Series  Number  Providing the person's contact detail's:  Street  Building no  Flat no  Postal code  City  Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Sumame  Hereby authorize Mr / Ms*  Name  Number  Number	I, the undersigned Name							8	Surname	e											$\neg$
Name and surname of child**  Child PESEL (Polish Resident Identification Number)**  Child PESEL (Polish Resident Identification Number)**  I state that to obtain information on my / my child's* state of health and health services:  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Surname  Holder of ID card*  Passport*  Series  Number  Pessel (Polish Resident Identification Number)  Date of birth  Providing the person's contact detail's:  Street  Building no  Flat no  Postal code  City  Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Surname  Holder of  ID card*  Passport*  Series  Number	Holder of ID card*		Passpo	ort*	Serie	es		<u>'</u>	Numbe	er _											_
Child PESEL (Polish Resident Identification Number)**  I state that to obtain information on my / my child's* state of health and health services:    Do NOT authorize anyone*	PESEL (Polish Resident Identification	n Number	-)		$\bigcap$				$\bigcap$			Date of	birth		<b>–</b>			_ [	$\overline{}$	$\prod$	
I state that to obtain information on my / my child's* state of health and health services:    Do NOT authorize anyone*	Name and surname of child**						<del></del>						`								_
Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number  PESEL (Polish Resident Identification Number) Date of birth — — — — — — — — — — — — — — — — — — —	Child PESEL (Polish Resident Identific	cation Num	nber)**								Child	date of b	oirth**		<b>—</b>			_ [			
Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number  PESEL (Polish Resident Identification Number) Date of birth — — — — — — — — — — — — — — — — — — —																					_
Name							alth s	ervices	i.												
Holder of ID card* Passport* Series Number  PESEL (Polish Resident Identification Number) Date of birth — — — — — — — — — — — — — — — — — — —		He	reby aut	horize	Mr / Ms																$\overline{}$
PESEL (Polish Resident Identification Number)  Providing the person's contact detail's:  Street  Building no  Flat no  Postal code  City  Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Surname  Holder of  ID card*  Passport*  Series  Number				J			ame														
Providing the person's contact detail's:  Street  Building no  Flat no  Postal code  City  Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone*  Hereby authorize Mr / Ms*  Name  Surname  Holder of  ID card*  Passport*  Series  Number				ort*	Serie	es	$\overline{}$		Numbe	er					$\exists$	$\overline{}$	_	_	<del></del>	~~~	_
Street Building no Flat no  Postal code City Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number	·		-)									Date of	birth								
Postal code City Country  Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number	Providing the person's contact deta	ail's:										$\neg$		_					_		
Phone number  I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number	Street											ا	Building —	no				Flat n	<u> </u>		_
I state that to obtain my / my child's* medical records (including medical results)  Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number	Postal code																				
Do NOT authorize anyone* Hereby authorize Mr / Ms*  Name Surname  Holder of ID card* Passport* Series Number					City									Countr	у						
	Phone number			J	City									Countr	у						
PEOPL (Pallat Paridant Hawking Manular)	I state that to obtain my / my child's  Do NOT authorize anyone*				ding me	<b>;</b> *		)						Countr	у						_
PESEL (Polish Resident Identification Number)	I state that to obtain my / my child's  Do NOT authorize anyone*  Name		reby aut	horize	ding me	s* Surna		)	Numbe	er				Countr	у						
Providing the person's contact detail's:	I state that to obtain my / my child's  Do NOT authorize anyone*  Name	He	Passpo	horize	ding me	s* Surna		)	Numbe	er		Date of		Countr	y			_ [			_
Street Building no Flat no	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification)	Hel	Passpo	horize	ding me	s* Surna		)	Numbe	er		Date of		Countr	y						
Postal code City Country	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification  Providing the person's contact details	Hel	Passpo	horize	ding me	s* Surna		)	Numbe	er			birth (		y		•	<b>–</b> [	•		
Phone number	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification  Providing the person's contact deta	Hel	Passpo	horize	ding me	s* Surna		)	Numbe	or			Building	ı no [				<b>■</b> [	0		
I hereby declare, I have been informed that any information about my/my child's state of health, provided health services and medical records are available only for patient legal guardian/representative, authorized person and public authorities (e.g. court). Without authorization we would not make any of the above mentioned details available.	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification  Providing the person's contact detain Street  Postal code	Hel	Passpo	horize	ding me	s* Surna			Numbe	or			Building	ı no [				<b>-</b> □	0		
Date Date	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification  Providing the person's contact deta  Street  Postal code  Phone number  I hereby declare, I have been inform	Hei	Passpo	horize	ding me Mr / Ms Serie City	Surna es	hild's	state of	health,	provid		ı service	Building	no Countr	у		e avai	lable	only f		
Signature of the person completing the statement (legible)  Signature of the person receiving the statement (legible)	I state that to obtain my / my child's  Do NOT authorize anyone*  Name  Holder of ID card*  PESEL (Polish Resident Identification  Providing the person's contact deta  Street  Postal code  Phone number  I hereby declare, I have been inform legal guardian/representative, authorized.	Hei	Passpo	horize	ding me Mr / Ms Serie City	Surna es	hild's	state of	health,	provid		ı service	Building	no Countr	у		e avai	lable I deta	only f		

In case of patients aged between 16 and 18 years old the statement must be signed by patient and legal guardian/representative

(\*) Mark the correct one.

(\*\*) Fill if applicable.