FAKULTNÍ NEMOCNICE OLOMOUC
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Clinic/Department: .....

Document No.:
Fm-L009-001-AMBUL-004

Version No.: 3

Instructions and Patient Informed Consent to Admission into Outpatient Care

Patient – first name and surname:	Personal ID No. (Policyholder No.):
Date of birth: (if different from Personal ID No.)	Medical insurance company No.:
Patient's permanent address: (or any other address)	

I have been instructed on the reasons for the admission into outpatient care specified as follows:

Consent:

How to complete (mark): **Delete where not applicable**	YES	~~NO~~

I consent to the admission into outpatient care.	YES	NO
I consent that individuals gaining qualification for the performance of a healthcare job (students at secondary medical schools, colleges, Medical Faculty of Palacký University, etc.) may provide medical and nursery care within the framework of their classes, in accordance with the internal rules of the University Hospital Olomouc.	YES	NO
I consent that the above-mentioned individuals may inspect my medical records to an extent which is absolutely necessary. All these individuals are obliged to maintain confidentiality about the facts learnt and about my Personal ID No.	YES	NO
I consent that external healthcare auditors consult my medical records in connection with their inspection activity. They are obliged to maintain confidentiality about all the facts learnt.	YES	NO

I request that the following individual(s) is (are) informed about my medical condition:			YES	NO
First name and surname:	Address:	Tel:		
I request that the above-mentioned individual(s) has (have) the right to:				
a) Inspect my medical records.			YES	NO
b) Make abstracts, duplicates or copies of my medical records*.			YES	NO

*The healthcare facility may charge a fee for making abstracts, duplicates or copies of the medical or other records not exceeding the cost of their making (Section 67bb, Par. 4, Letter b) of Act 20/1966 Coll., on public healthcare.

Date:	Hour	**Patient's signature**

First name and surname of the doctor who instructed the patient	**Signature of the doctor** who instructed the patient	Seal of the healthcare facility

If the patient is unable to sign, specify the reasons why the patient could not attach his/her signature:			
How did the patient express his/her will:			
First name and surname of the healthcare worker/witness	Signature of the healthcare worker/witness	Date:	Hour