



BUDAI EGÉSZSÉGKÖZPONT

*Biztonság és szakértelem*

## DECLARATION

### ON THE RECEIPT OF MEDICAL DOCUMENTS BY OTHER PERSON

I, the undersigned (name: ....., mother's name: ....., place and date of birth: ....., address:.....), am receiving medical treatment provided by Budai Egészségközpont Zrt. (1126 Budapest, Királyhágó u. 1-3., Reg.Nr.: 01-10-141707, ), hereinafter referred to as the "**Buda Health Center**"). I hereby confirm that I have full legal capacity, and pursuant to Section 16 (1) a) of Act CLIV of 1997 (hereinafter referred to as the "**Healthcare Act**"), **I hereby designate** .....**(name)** (place and date of birth: .....; mother's name: ....., address:.....) **to receive the information** on my medical treatment under Section 13 of the Healthcare Act and **to be given the documents** containing medical information related to my medical treatment until otherwise specified by me by my declaration.

Buda Health Center informed me on its privacy policy, which is available at its web page (<https://www.bhc.hu>) and at all venues where it provides medical services.

Budapest, .....

.....

Signature

#### In our presence as witnesses:

Name: ..... Signature: .....

Address: .....

Name: ..... Signature: .....

Address: .....

**BUDAI EGÉSZSÉGKÖZPONT ZRT.**

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Superbrands

