Regionaalhaigla

CONSENT FOR THE RELEASE OF HEALTH DATA OR DOCUMENTS

Details of the person granting consent (the patient or their legal representative):

first name and surname ..... ……

personal identification code (in the absence thereof, date of birth).....

phone number ..... e-mail address .....

Details of the recipient of data or documents (in the event of a legal person, specify the name of the institution, registry code of the institution, and details of the representative):

first name and surname .....

personal identification code/registry code .....

document number/representative's details .....

I grant my consent for the release of the health data or documents about me:

☐ medical history/excerpt ……
/which medical history/excerpt or which part of a medical history/

☐ analysis results ……
/which analysis results/

☐ radiological examination images on a digital carrier .....
/which examinations/

☐ description of radiological examinations ……
/which examinations/

☐ other document ……
/which document/

Comments ……

……

I confirm that I am giving my consent voluntarily.
I am aware that I may withdraw my consent at any time up to the release of the data or documents by e-mailing the respective notification to info@regionaalhaigla.ee or by calling 617 1101.

The signed application for withdrawing consent must be submitted within **5 (five) working days** after sending the notification on withdrawing consent. The application may be signed digitally and e-mailed to info@regionaalhaigla.ee, sent by post to J. Sütiste tee 19, 13419 TALLINN, or submitted in person at the information desk of Regionaalhaigla at J. Sütiste tee 19, Tallinn.

I have enclosed a copy of my identity document to this consent form.

Person granting consent .....
/name and surname/ /signature/ /date/