FNO
FAKULTNÍ NEMOCNICE OSTRAVA

UNIVERSITY HOSPITAL OSTRAVA
17. listopadu 1790/5, 708 52 Ostrava-Poruba, Czech Republic

SAK AKREDITOVÁNO

Informed Consent

Declaration of patient / legal representative – hospitalization

I hereby declare, that upon the admission to University Hospital Ostrava (hereinafter referred to as FNO), **I have been informed by the physician in understandable way and in sufficient extent about my medical condition, the reasons of hospitalization and the proposed individual treatment procedure, which may include common diagnostic, laboratory and imaging procedures, and administration of medication. I was given the possibility to ask additional questions, which were answered in full. I give my consent [1] with the hospitalization at FNO, and I am aware of the fact, that this consent applies also to all transfers within one hospitalization at FNO. I am also aware of the fact, that I may change my decision at any time in the course of inpatient care provided at FNO by filling-in a new "Proclamation" form.**

I have been informed about the price of provided services, which are not covered, or are only partially covered from public health insurance.

I hereby declare, that I have not withdrawn any information regarding my medical condition, which may unfavourably alter the course of my treatment or pose a threat to my surrounding, especially contagious diseases.

I hereby declare, that I have been instructed about the rights pertaining to provision of information regarding my medical condition and the possibility to look into my medical record, including making copies of such.

I hereby declare, that I have been informed about the fact, that information regarding my person (identification data), and the data related to my medical condition in regards to the inpatient care, are subject to compulsory reporting to the Institute of Healthcare Information and Statistics of the Czech Republic, in the extent defined by law.

With the signature (on the reverse page) **of the form I declare, that I have been informed about the reasons for admission to FNO, and that I my give consent with the inpatient treatment[1]. I am aware of the fact that I may withdraw my consent at any time by filling-in a new "Declaration of patient / legal representative" form. Withdrawal of the consent does not affect the lawfulness of processing of personal data based upon the consent, which had been given prior to its withdrawal.**

1. **I hereby declare, that I have been informed about the possibility to waive the information regarding my medical condition.**
   ☐ **I wish to receive information [2] / ☐ I waive the right to receive the information [2]**
2. I am aware of the fact, **that FNO is a research and educational institution, especially in relation to medical faculties and medical schools**
   I hereby ☐ agree [2] / ☐ disagree [2] with the presence of students preparing for the performance of healthcare profession and their pedagogical supervisors in the course of care provided during hospitalization.
3. **I hereby ☐ agree [2] / ☐ disagree [2]** that the students preparing for the performance of healthcare profession, their pedagogical supervisors and FNO employees participating in research activities, may look into my medical record, to the necessary extent, and only on the authorization of a healthcare professional.
4. **I hereby ☐ agree [2] / ☐ disagree [2]** that the non-medical employees of internal and external auditing authorities may look into my medical record in relation to monitoring the quality of provided medical care.
5. I have been informed by my attending physician about the importance of taking audio-visual recordings (e.g. photographs, audio or video recordings), in the course of my treatment.
   I hereby ☐ agree [2] / ☐ disagree [2] with the use and presentation of the audio-visual recordings at seminars of healthcare establishments, congresses, or publication of the recordings in expert medical journals. The recordings will depict only the parts of my body, which are directly related to the treatment. I have been informed, that none of my personal data (name, surname), other sensitive data (date of birth, birth number), or other characteristics, which could lead to identification of my person will be ever revealed.

I may withdraw my consent given in points 1-5 at any time during my stay at FNO by filling-in a new form "Declaration of patient / legal representative". Withdrawal of the consent does not affect the lawfulness of processing of personal data based upon the consent, which had been given prior to its withdrawal.

PLEASE CONTINUE READING ON THE REVERSE SIDE!

[1] Negative Consent must be signed in cases when the patient refuses the hospitalization
[2] Please tick the appropriate box

R E C O R D
OF CONSENT WITH PROVIDING INFORMATION REGARDING THE MEDICAL CONDITION OF THE PATIENT

Please select one of the following options (A, B) and indicate your selection with a cross:

☐ A) I hereby declare, that **I give my consent to providing information** regarding my medical condition[3] (medical condition of the patient[4])**, looking into my medical record**[3] **and the possibility to make copies**[3] **of the medical record** **to the full extent** **by the following persons** (name and surname, address):

I hereby declare, that **I give my consent to providing information** regarding my medical condition[3] (medical condition of the patient[4])**, looking into my medical record**[3] **and the possibility to make copies**[3] **of the medical record** **in limited extent** **by the following persons** (name and surname, address):

-------------------- in the extent: --------------------

-------------------- in the extent: --------------------

☐ B) **I forbid** to provide information regarding my medical condition (medical condition of the patient[4]), to look into the medical record and make copies of such to all persons.

I hereby declare, that I give consent to the following persons proclaiming consent of disapproval with the provision of medical services to my person in cases, when I, due to my medical condition, will not be able to pronounce such consent or disagreement personally:

I am aware of the fact, that no other persons, apart from those listed here, will not be informed about my medical condition (medical condition of the patient[4]) **by the healthcare professionals. I may withdraw my consent at any time by filling-in a new form. Withdrawal of the consent does not affect the lawfulness of processing of personal data based upon the consent, which had been given prior to its withdrawal.**

In cases when the above-listed persons wish to be informed about the medical condition of the patient via telephone, they must agree with the attending physician upon an identification password for safe communication.

Password: --

Title, name and surname of the patient:		Birth number:	
Title, name and surname of the legal representative		Birth number:	

In Ostrava, on:		**SIGNATURE OF THE PATIENT / LEGAL REPRESENTATIVE:**	

Responsible FNO physician (stamp)**:**		Signature:	

In case the patient is not able to sign the consent:
The patient, due to his/her medical condition (reasons: …………………………………………..…....…), cannot sign the "Declaration". The patient pronounced his/her consent in the following way: …...……...…..…………..……………… .

In such cases, the "Declaration" must include a signature of another healthcare professional (witness):

Healthcare professional of FNO (stamp):		Signature:	

This "Declaration" is elaborated in one copy, which is filed in the patient's medical record and becomes a part of such. The patient may receive a copy upon request.

[1] specify for the respective person, whether he/she is entitled to receive information regarding the patient's medical condition, look into the medical record or make copies of such; unless stated otherwise, the person has all these rights
[2] in cases when the consent is pronounced by a legal representative