**CONSENT**

**to the collecting and processing of personal data**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

full name, date of birth, phone number, document (passport) series, number, issuing authority, date of issue

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Residing at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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hereby confirm my consent to the processing of my personal data by the Federal Hygienic and Epidemiological Centre of Rospotrebnadzor (TIN 7726008570, located at 19A Varshavskoye Shosse, 117105, Moscow, Nauchno-Proizvodstvennaya Firma Helix (TIN 7802122535, located at 20 A, Bolshoy Sampsonievsky Prospekt, 194044, St. Petersburg), (hereinafter referred to as the "Operator") in accordance with the requirements of article 9 of the Federal Law on Personal Data No. 152-FZ dated 27 July 2006, article 13 of the Federal Law on Healthcare Fundamentals for Citizens in the Russian Federation No. 323-FZ dated 21 November 2011. I authorize the Operator to process my last name, name, patronymic, sex, date of birth, home address, job address, telephone numbers, email address, passport (ID card details) details, health insurance policy details, data about my health, diseases, results of laboratory tests, cases of seeking medical help, and other relevant information provided for medico-prophylactic purposes, making a medical diagnosis, providing medical assistance, and implementation of other related measures, as well as for the purpose of organizing the internal accounting of the Operator provided preservation of medical secrecy. Furthermore, in the process of providing medical services by the Operator to me (or the person I represent), I authorize healthcare workers to transfer my personal data (or personal data of the person I represent), including personal data constituting medical secrecy, to other officials of the Operator in the interests of my examination, treatment, and internal accounting of the Operator. I authorize the Operator to perform all actions (operations) with my personal data, including collection, systematization, accumulation, storage, updating, change, use, transfer (to an insurance medical organization and customer of medical services as part of concluded contracts), depersonalization, blocking, destruction.

The Operator shall be entitled to process my personal data in the following ways: on paper, in personal data information systems with and without the use of automation, as well as in a combined manner.

The Operator shall be entitled to collect and process personal data by entering it into an electronic database, including lists (registers), and reporting forms outlined in documents governing the provision of reporting data (documents) under the health insurance contract and the contract for paid medical services. The Operator may exchange (receive and transfer) personal data with the insurance medical organization and the organization customer of medical services when performing its obligations under the contracts mentioned above. This exchange may occur through machine-readable media, communication channels, or paper documents, without the need of notifying me about it. However, processing and reception will be conducted by an individual who is bound by professional secrecy.

I hereby give my consent for the Operator to use my personal data to send me messages via communication means such as email and text messages (SMS). This will include the results of laboratory tests to my indicated email address.

I have been duly informed that third parties may access the information sent through email. The Operator shall not be held responsible for unauthorized access to the mailbox, information leakage, or failure to receive sent results.

Personal data will be retained for the same duration as primary medical documents (medical records). This duration is 25 years for inpatient clinics and 5 years for outpatient care.

Any transfer of personal data to other parties or disclosure must be done with my written consent.

This consent remains valid indefinitely and can be withdrawn by sending a written document to the Operator (by registered mail with acknowledgment of receipt) or delivering it to an operator representative and signing for receipt.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the personal data subject Date

(or their legal representative)

(REVERSE SIDE)

**Informed voluntary consent for the types of medical interventions**

**included in the list of certain types of medical interventions**

**for which informed voluntary consent is given when selecting a doctor and medical**

**institution for primary healthcare services**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(full name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth, registered at:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

and domiciled at (if different from registered address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby give my informed voluntary consent for the types of medical interventions included in the list of certain types of medical interventions for which informed voluntary consent is given when selecting a doctor and medical institution for primary healthcare services as approved by Order No. 390n of the Ministry of Health and Social Development of the Russian Federation dated 23 April 2012 (registered by the Ministry of Justice of the Russian Federation on 5 May 2012 No. 24082) (hereinafter referred to as the "List"). This consent is for the purpose of receiving primary health care, specifically COVID-19 diagnostic test at Nauchno-Proizvodstvennaya Firma Helix located at 20 A, Bolshoy Sampsonievsky Prospekt, 194044, St. Petersburg.

I have been fully informed of the goals, methods of medical care, the associated risks, and possible options for medical interventions, including the potential consequences and likelihood of complications, as well as the expected outcomes of medical care, all of which were explained to me in an understandable manner by the healthcare worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(position, name of healthcare worker)

It has also been made clear that I have the right to refuse one or more of the medical interventions listed or to request their discontinuation, except as provided in part 9, article 20 of the Healthcare Fundamentals for Citizens in the Russian Federation No. 323-FZ dated 21 November 2011.

Furthermore, I have selected an authorized person to whom information regarding my health condition, specifically the results of the laboratory examination for COVID-19, may be disclosed, in accordance with paragraph 5, part 5, article 19 of the Healthcare Fundamentals for Citizens in the Russian Federation N 323-FZ dated 21 November 2011. The full name and contact number of the authorized person is provided below:

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(full name of the authorized person, contact number)

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| --- | --- | --- | --- |
|  |  |  |  |
| (signature) |  | (full name) |  |
|  |  |  |  |
| (signature) |  | (full name of the healthcare worker) | (date) |