BUDAI EGÉSZSÉGKÖZPONT

Statement
of receipt documents containing medical information

I, the undersigned (name: ……, mother's name: ……., place and date of birth: ……), am receiving medical treatment provided by Budai Egészségközpont Korlátolt Felelősségű Társaság (company registration number: 01-09-692609, VAT number: 12560044-2-43, place of business at H-1126 Budapest, Nagy Jenő u. 8., hereinafter referred to as the "**Buda Health Center**"). I 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: ……) to receive the information 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.

Budapest, ……

……..
Signature

In our presence as witnesses:

Name: …… Signature: ……

Address: ……

Identity card no.: ……

Name: …… Signature: ……

Address: ……

Identity card no.: ……