Template form

Consent for Personal Data Processing and Transfer of Confidential Medical Information

I, _____, passport: ____ _____,
(full name)
issued by _____ (issuing authority) _____ (date of issue),
registered at the address: _____
(registration address)
(hereafter, the "Student"), under the Paid Medical Services Agreement (hereafter, the "Agreement") signed between National Research University Higher School of Economics (hereafter, "HSE University") and Municipal Polyclinic No. 3 under Moscow City Healthcare Department (hereafter, the "Medical Institution"),

as per Article 9 of Federal Law No. 152-FZ, dated July 27, 2006 "On Personal Data", hereby provide my consent for the processing of my personal data by authorised staff of the Medical Institution, including: last name, first name, patronymic/middle name, gender, place of birth, date of birth, citizenship, place and date of registration, place of residence, residential address, details of the identity document (passport), email address, contact phone number, details of the voluntary health insurance policy (if any), SNILS, information about my health status (including, but not limited to, medical history, diagnosis), history of seeking medical care, a list, duration and scope of medical care services provided and other personal data processed for the purposes of establishing a medical diagnosis and providing medical services, as well as for the purposes of enabling registration and control in the mandatory and voluntary health insurance systems, ensuring quality assurance, and safety of medical services (hereafter, the "Personal Data").

I hereby provide the Medical Institution with the right to process my Personal Data, i.e. its collection, systematisation, accumulation, storage, updating, modification, use, depersonalisation, blocking, and destruction, including data processing by inputting my Personal Data into an electronic database.

I hereby provide the Medical Institution with the right to transfer my Personal Data and confidential medical information, including laboratory test results, as part of the Agreement, to HSE University, as well as the following authorised representative of HSE University:

_____
(full name, contact phone number)

This Consent has been provided for an unlimited period of time. The Consent can be withdrawn by submitting a written request to the Medical Institution in hardcopy against signed acknowledgement.

I am aware that the laboratory test results will be submitted by the Medical Institution to the HSE University's authorised representative specified herein.

Upon submission of the laboratory test results to HSE University, the Medical Institution will bear no responsibility in case of any violation of confidentiality obligations on the part of HSE University.

Student	Medical Institution
_____/_____	_____/_____
_____202__ .	_____202__ .