Template form

Informed Voluntary Consent
to Undergo Medical Examination
Provided by a Foreign National or Stateless Person
(Their Legal Representatives)

I, _____ (full name of foreign national), a citizen of _____ (specify country or add "stateless person"), born on "__" _____ ___ , registered at the following address: _____ (residential address of foreign national or their legal representative), hereby provide an informed voluntary consent to undergo medical examination, conducted in accordance with Paragraph 7 of the Procedure for Confirming the Presence or Absence of Infectious Diseases That Pose a Danger to Others and Serve as Grounds for Refusal to Issue or Cancellation of a Temporary Residence Permit, Residence Permit, Patent, or Work Permit Issued to a Foreign National or Stateless Person in the Russian Federation, approved by Directive N 384н of the Ministry of Health of the Russian Federation, dated June 29, 2015, or allow the patient whom I legally represent to undergo medical examination (cross out the option that does not apply) at _____ (full name of medical institution).

The medical officer _____ (job title and full name of the medical officer) has clearly explained to me the goals, methods of medical examination, associated risks, possible types of medical interventions and their consequences, including the likelihood of complications, as well as the expected results of medical examination. I have been informed that I have the right to refuse to undergo one or more types of medical interventions included in the List or to demand that such interventions are ceased, except in cases specified in Part 9, Article 20 of Federal Law No. 323-FZ "On the Fundamentals of Health Protection of Citizens in the Russian Federation," dated November 21, 2011.

Details of individuals who, in accordance with Paragraph 5, Part 5, Article 19 of Federal Law No. 323-FZ "On the Fundamentals of Health Protection of Citizens in the Russian Federation," dated November 21, 2011, will be entitled to receive information on my health condition (including after my death) or the health condition of the patient whom I legally represent (including after my their death)(cross out the option that does not apply):

_____
(full name, contact phone number)

_____	_____
(signature)	(full name of the patient or their legal representative)
(signature)	(full name of medical officer)

"__" _____ ___
(date of signing)