CLINIC ANALIZA
Spinčićeva ulica 2/B, 21000 Split
OIB: 91949816496
Phone: +385 21 688 888
www.poliklinika-anliza.hr

NAME AND SURNAME OF THE PATIENT (in block letters)

.....

ADDRESS:.....

PHONE / MOBILE NUMBER:.....

EMAIL:.....

Respecting the provisions of Article 6 of the General Regulation on Data Protection - (EU) 2016/679 - of the European Parliament, which applies in the Republic of Croatia according to the Act Implementing the cited Regulation, OG 42/18, I give to the Polyclinic "Analiza" the following

CONSENT FOR THE PROCESSING OF PERSONAL DATA

My data, according to the definition from Article 4 of the Regulation, I give to the POLYCLINIC "ANALIZA" for the purpose of:

- SENDING RESULTS BY EMAIL **YES**
- SENDING RESULTS BY MAIL **NO**
- CONTACTING BY PHONE / MOBILE PHONE **YES**

- SENDING MARKETING MATERIALS AND BENEFIT NOTICES, AND NOTICES ABOUT PROMOTIONS AND DISCOUNTS, SPECIAL OFFERS, PRIZE GAMES AND DRAWINGS, SURVEYS AND SURVEYS BY EMAIL

NO

We will pass on your data to third parties as needed, but only to provide medical services and in cases provided by law. We will treat your data confidentiality and per the General Data Protection Regulation under its purpose and regulations.

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I give my consent voluntarily and by signing it I confirm that I am aware that I can withdraw my consent at any time without any negative consequences. I am also aware that, per the General Regulation on Personal Data Protection, I may, under certain conditions, exercise my rights to obtain confirmation of processing, inspect my data, correct or supplement my data, object to further or excessive processing, block illegal processing, request the deletion of my data and receive a copy of personal data for transfer to another controller.

I confirm that the head of personal data processing informed me that all other information related to the processing of my data can be obtained by inquiring at the email address info@mcanaliza.org and that I can file a complaint about the processing of personal data at the same email address.

SIGNATURE:..... **DATE:** .....

If the patient is under 16 years of age or unable to understand consent:

NAME AND SURNAME OF PARENT / GUARDIAN: .....

SIGNATURE OF PARENT / GUARDIAN: ..... **DATE:**.....