**Informed voluntary consent of a parent (legal representative) of a student for examination and (or) hospitalization of a minor for medical reasons in a healthcare organization located outside**

**the FSBEI RCC "Ocean"**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(surname, first name, patronymic of the parent (legal representative)

«\_\_\_» \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year of birth, registered at the address:

(date of birth of the parent/legal representative) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(registration address of the parent/legal representative)

regarding\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(surname, first name, patronymic of the child)

«\_\_\_» \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year of birth, living at the address:

(date of birth of the child)

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

(in case of residing outside the place of residence of the parent/legal representative)

give informed voluntary consent in case of necessity and availability of the reasons for examination and (or) undergoing inpatient treatment outside the FSBEI RCC "Ocean" (hereinafter - the Center), in the interests of maintaining and improving the health of the person, whose parent (legal representative) I am. I agree to the hospitalization of this person in a healthcare organization to provide the necessary medical care, including surgical, gynecological, urological, narcological and psychiatric care, in healthcare organizations licensed to provide medical care for these types of activities and the processing of personal data: surname, first name, patronymic (if available), date and place of birth, address, contact telephone number, health insurance policy, SNILS, data on the state of health, diseases; other information requested by the hospital staff obliged to maintain professional secrecy as part of compliance with the legislation of the Russian Federation in relation to the minor.

I understand that I have the right to:

- learn about the goals and methods of medical assistance, associated risks, consequences, complications;

- refuse to hospitalize the minor for medical reasons in a medical organization located outside the Centre for the purposes of providing primary medical and sanitary care and specialized medical care, or demand its termination, except in the cases provided for in part 9 of article 20 of Federal Law No. 323-ФЗ of 21 November 2011 "On the Fundamentals of Health Care for Citizens in the Russian Federation".

This consent shall be valid for the duration of my child's stay at the Center.

I reserve the right to withdraw my consent by drawing up a corresponding written document, which can be sent by me to the Center by registered mail with acknowledgement of receipt, or delivered in person against signature to a representative of the Center.

Date: «\_\_\_» \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/

(signature) (full name)