1. PATIENT'S CONSENT TO TREATMENT OR INTERVENTION

Undersigned, #!NEV; (name); Social Security Number: …….; living address:#!BVAROS;, #!BUTCA;; hereby I declare the following:
This is to certify that I have been informed by dr . . . . . of the following:
My illness, according to the diagnose/presumably is: ……
……
I am hereby giving my consent to perform on me the examinations and additional interventions as follows:
……
……
…….
as well as to perform on me the following instrumental examination(s) and treatment(s):
……..
…….
The suggested therapy, which is (in Hungarian):
……
……..…
its most frequent risks, real and disadvantageous complications and its expectable advantages:
……
…….
any alternative therapies and their possible disadvantages:
……

Hereby I declare that **I have received** appropriate information about the nature and purpose of the interventions and treatment, about the expectable advantages and risks, about the possibilities of complications which can occur in spite of the obligatory precautions, as well as about the other possibilities of treatment of my illness.
I have been informed about the possible impairment in my health state in case any of the above interventions are omitted.
I give my consent to receive medicaments, narcotics or any other substances **thought necessary to** my treatment.
I take notice of the fact that all **tissues and organs** removed from me during the intervention or treatment, **would be taken to** pathological and histological **examination**, moreover, I give my consent to their further possible utilizing.
I take notice of the fact that in case any **infectious disease is observed or suspected** in me during my treatment at the hospital, a **red, patient identifying band** will be put on my wrist to keep myself, the other patients and the workers at the hospital safe.
I give my consent for the personnel to take **photographs or video recordings** during the interventions or treatment under the reservation that my personality should not be recognizable.
I know that within the hospital, training of health personnel is going on, that is why **I give my consent** to be treated by not only by physicians, but **medical students and other health ancillary workers** – in the presence and supervision of a responsible person – who are also bound to professional secrecy.
I take notice of the fact that, the intervention on me will be performed or directed by the physician assigned by the Head Physician of the Department **in order I should receive professional treatment necessary in my health state and in accordance of Health Act**.
I found the received information sufficient for me, I shall need further information in case performing other interventions will become necessary. If in spite of the received detailed information, I shall refuse any interventions or treatment, I shall assume responsibility for their consequences, and I shall relieve those physicians of responsibility, whose medical intervention I refused. On the basis of this, I shall make demands neither on them, nor on the institute.

2. TAKING PRIVATE MEDICAMENTS

I take notice of the fact that I can take any medicine not provided by the hospital only at my own risk and the hospital refuses responsibility for any possible impairment in my health, for any deterioration of my health state or for failing any remission resulting from it.

3. INFORMATION ABOUT PREVIOUS ILLNESSES AND ABOUT THEIR TREATMENT

I take notice of the fact that in accordance with my/the patient's obligations posited in the Health Act, I have to inform health personnel taking part in my treatment about everything that is necessary to establish the diagnose, to prepare an appropriate treatment/interventions plan, especially about all of my previous illnesses, their medical treatment, or taking any curative preparations or about any risk factors that can be harmful to my health. **I shall inform them** – in relation to my health – about all those factors that can threaten life of others or be harmful to their health, especially about infectious diseases; and if I have any infectious diseases, I name those persons I could get the disease from, or those who could get the infection from me.

4. DATA PROTECTION

You are asked **to put an "X" into the appropriate rubrics of "yes" or "no",** in the following table according to your disposal! Please answer all questions **with an X put only in one of the columns!**

	yes	**no**
I give my permission to inform those interested (at the reception desk or by phone) about the fact that I am hospitalized, and about the name of the department where I am treated.		
My close relatives can look into my health documents.		

Please, put the **name, living address and phone number of the appropriate** person to the rubrics see below, or **line it through**, if you want to leave it empty.

	Name	**Living address**	**Phone number**
Please, inform this person about my health state and my hospitalization:			
Hereby I disclaim my right to receive any information; please inform this person instead of me about the details of my illness			

To exercise other rights (e.g. any consent or refusal of interventions) can be delivered to other persons only with an authenticated notarial document or private record. You can ask your physician about this.

Note:

I have read the information about patients' rights and I have taken notice of it.

5. FOOD CONSUMPTION

I take notice of the fact that, I can consume any food products besides those received at the hospital only at my own risk, and I shall inform my attending physician about this.
Food products necessitating cooling must be stored in the refrigerator labelled with my name.
I give my consent that any food products influencing my health state negatively can be eliminated by the nurse without asking my permission to do that.

6. SAFEGUARDING VALUES

I take notice of the fact that any therapeutical equipments e.g. crutches, dental prosthesis, spectacles, etc. **belonging to my property**, as well as other personal things will remain with me during my hospitalization. The hospital refuses any responsibility for their loss or disappearance.
At your request, it is possible to safeguard your values (mark the appropriate space with X):

☐ I require ☐ I do not require

I take notice of the statements in the above points, and I give my consent to them; I do not give my consent to the statements in points ……

Sopron, 20 . . . .

Signature of the patient, legal representative or the authorized relative	Signature of the physician giving the information	Signature of the nurse present at the admission to the hospital