

Participant ID _____

Informed Voluntary Consent for Medical Intervention

I, _____

(Full Name, Date of Birth)

Address of Registration, Address of Residence (also specified if different from the registration address):

give informed voluntary consent to the types of medical interventions included in the List of Certain Types of Medical Interventions. This includes the primary medical care for which citizens provide informed voluntary consent when choosing a doctor and medical organization, approved by order of the Ministry of Health and Social Development of the Russian Federation dated 23 April 2012 No. 390N (hereinafter referred to as the types of medical interventions included in the List). This includes service for taking a swab for laboratory testing of biological material. The medical service for laboratory testing of biological material is provided by the Federal Budgetary Institution of Healthcare “Federal Hygienic and Epidemiological Center” of the Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing. The medical service for collecting biological material for laboratory testing purposes (taking a swab) is provided by organizations on a territorial location: for patients receiving the service in the city of Samara — by the following institutions, depending on the selected testing site:

- State Budgetary Healthcare Institution of the Samara Region “Samara City Consultative and Diagnostic Polyclinic No. 14”;
 - State Budgetary Healthcare Institution of the Samara Region “Samara City Hospital No. 7”;
 - State Budgetary Healthcare Institution of the Samara Region “Samara City Hospital No. 4”;
 - State Budgetary Healthcare Institution of the Samara Region “Samara City Polyclinic No. 3”,
- for patients receiving the service in the city of Moscow – by

this box should be completed by the organization that provides collecting biological material

The healthcare provider has thoroughly explained to me the objectives, methods of treatment, potential risks, available medical interventions, their implications, including possible complications, and the anticipated outcomes of treatment in a manner that I can easily understand. I have been informed that I retain the right to decline specific medical interventions listed or to request their cessation, except in cases outlined in Part 9, Article 20 of the Federal Law of 21 November 2011, No. 323-FZ “On the Fundamentals of the Protection of Citizen’s Health in the Russian Federation”.

Information about my health may be disclosed to persons selected by me in accordance with paragraph 5 of part 3 of article 19 of the Federal Law of 21 November 2011, No. 323-FZ “On the Fundamentals of the Protection of Citizen’s Health in the Russian Federation”.

(Full Name of Selected Person, Contact Number. If unavailable, use a dash)

(Signature)

(Name of health care provider)

Date of completion _____ 2025

(Signature)

(Full name)

Participant ID _____

Consent to the Processing of Personal Data

I, _____
Full Name, Document (Passport), Series, Number, Issuing Authority, Date of Issue
Registered at the address:

In accordance with Federal Law of 27 July 2006 No. 152-FZ "On Personal Data", in order to provide me with medical services, I hereby confirm my consent to the processing of my personal data by the Federal Budgetary Institution of Healthcare "Federal Hygienic and Epidemiological Center" of the Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (INN 7726008570, address: 19A, Varshavskoye Shosse, Moscow, 117105) (hereinafter referred to as the Operator). This includes surname, first name, patronymic, date and place of birth, gender, citizenship, residence address (including registration information), workplace details, phone number, identity document details (series, number, date of issue, issuing authority), information regarding provided medical care, and health status data, including medical history, for the purpose of receiving medical services and ensuring compliance with the laws and regulations of the Russian Federation.

I hereby authorize the Operator to perform all actions (operations) or a set of actions (operations) in processing personal data, whether automated or manual, including collection, recording, systematization, accumulation, storage, clarification (update, change), extraction, use, transmission (provision, access), depersonalization, blocking, deletion, destruction of personal data.

The Operator has the right to process personal data by entering them into information repositories (electronic databases, lists, registers).

The storage period of personal data corresponds to the storage period of medical records.

Name of entities responsible for processing personal data on behalf of the Operator by authorizing employees of the said legal entities to process personal data, if such processing is delegated to them: Roscongress Foundation (INN 7706412930), address of location: Room 1101, Entrance 7, 12, Krasnopresnenskaya Naberezhnaya, Moscow, 123610.

Personal data may only be disclosed to other persons or otherwise disclosed with my written consent.

I reserve the right to withdraw my consent in writing, which may be sent to the Operator by registered mail with acknowledgement of receipt or personally delivered and signed for by the Operator's representative.

This consent is given by me and is valid for 1 (one) year, unless the consent is withdrawn in writing.

Date of completion _____ 2025

(Signature)

(Full name)