



**Microbiological  
Department**

**ORDER FORM AND CONSENT FOR  
SENDING TEST RESULT  
BY E - MAIL**

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**INFORMATION ABOUT THE PATIENT**

<b>Name and surname</b>	
<b>Date of birth</b>	
<b>Personal identification number</b>	
<b>Address</b>	
<b>E-mail</b>	
<b>Contact number (mob / tel)</b>	
<b>E-mail for submission of test result</b>	

**Place and date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

We treat the information you provide to us when filling out the form confidentially and in accordance with the legal regulations governing the protection of personal data. We use your information only for the purpose of protecting patient privacy.