

## Voluntary Informed Consent to Medical Intervention

I, \_\_\_\_\_  
full name and series, number, issuing authority, and date of issue of document (passport)

Residing at:

I hereby give my voluntary informed consent to the medical intervention included in the List of Certain Types of Medical Interventions for Which Citizens Give Voluntary Informed Consent, which was approved by Order No. 390N of the Ministry of Health and Social Development of the Russian Federation dated 23 April 2012 (registered by the Ministry of Justice of the Russian Federation as No. 24082 on 5 May 2012) (hereinafter the List) to provide me with the following medical service: to take a swab to detect SARS-CoV-2 RNA as part of receiving primary healthcare / primary specialized healthcare provided by INVITRO Independent Laboratory Limited Liability Company and the Federal Hygienic and Epidemiological Center of the Federal Service for the Oversight of Consumer Protection and Welfare. In a manner that was accessible to me, a medical worker explained to me the goals and methods of providing medical care, the risks associated with them, possible options for medical interventions and their consequences, including the likelihood of complications, as well as the expected results of the provision of medical care. It was explained to me that I have the right to refuse one or more types of medical interventions included in the List, or demand that it (they) be ceased, except for cases envisaged by Part 9 of Article 20 of Federal Law No. 323-FZ dated 21 November 2011 "On the Fundamentals of Protecting the Health of Citizens in the Russian Federation".

Below is information about the persons to whom I have chosen to provide information about the state of my health in accordance with clause 5 of Part 3 of Article 19 of Federal Law No. 323-FZ dated 21 November 2011 "On the Fundamentals of Protecting the Health of Citizens in the Russian Federation":

\_\_\_\_\_  
(full name of the chosen person and contact phone number, or strike through if there is no such person)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(full name of medical worker)

### CONSENT to the processing of personal data

In accordance with the requirements of Federal Law No. 152-FZ dated 27 July 2006 and for the purpose of providing me with medical services, I confirm my consent to the processing of my following personal data by the Federal Hygienic and Epidemiological Center of the Federal Service for the Oversight of Consumer Protection and Welfare (Taxpayer Identification Number 7726008570, address: 19A, Varshavskoye Shosse, Moscow, 117105) and INVITRO Independent Laboratory LLC (Taxpayer Identification Number 7710294238, Unified State Register of Legal Entities entry 1037739468381, address: room 3, premises I, floor 3, building 3, 16, 4-ya Tverskaya-Yamskaya Ulitsa, Moscow, 125047) (hereinafter the Operator): last name, first name, and patronymic, year, month, date, and place of birth, gender, citizenship, place of residence, including information about registration at the place of residence, place of accommodation, place of work, details of an identity document (series, number, issue date, name and subdivision code of the authority that issued the document), details of medical insurance policies, insurance number of an individual personal account with the Russian Pension Fund (SNILS), information about the medical care provided, information about social support measures, data on the current state of my health, including medically confidential data for the purposes of: **to take a swab to detect SARS-CoV-2 RNA as part of receiving primary healthcare / primary specialized healthcare**, ensuring compliance with the laws of the Russian Federation and other regulatory legal acts of the Russian Federation, and notifying the owner of the personal data about the results of the test using the federal state information system Unified Portal of State and Municipal Services to determine whether the causative agent of the coronavirus infection (COVID-19) is present and the Organizer of the event about whether the pathogen coronavirus infection (COVID-19) is present.

When processing my personal data, I hereby grant the Operator the right to carry out all actions (operations) or a set of actions (operations) performed with or without the use of automation tools with personal data, including the collection, recording, systematization, accumulation, storage, clarification (updating or modification), extraction, use, transfer (distribution, provision, or access), depersonalization, blocking, deletion, and destruction of my personal data.

The Operator may process my personal data by entering it into information repositories (electronic database, lists, registers, or registries).

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

My personal data may only be transferred to other persons or disclosed in another manner with my written consent.

I reserve the right to withdraw my consent in writing, which may be sent to the Operator's address by registered mail with acknowledgment of receipt, or delivered personally against receipt to a representative of the Operator.

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

DATE \_\_\_\_\_ 2023

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(full name)