NASTAVNI ZAVOD ZA JAVNO ZDRAVSTVO **Microbiological Department**	**ORDER FORM AND CONSENT FOR SENDING TEST RESULT BY E - MAIL**	Document label: **OB 5.9/1-0/4-400** Edition: 3 Page/page: 1/1 **Z –400/ -20**

INFORMATION ABOUT THE PATIENT	
Name and surname	
Date of birth	
Personal identification number	
Address	
E-mail	
Contact number (mob / tel)	
E-mail for submission of test result	

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.