HOSPITAL DE LA SANTA CREU I SANT PAU
UNIVERSITAT AUTÒNOMA DE BARCELONA

User Service Department
FGS Hospital de la Santa Creu i Sant Pau
Carrer de Sant Quintí 89, 08041 Barcelona
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FORM FOR EXERCISING THE RIGHT TO CANCEL [(1)]

Details of the interested party [(2)]

Full name | Clinical record number / Personal ID code

National Identity Card/Foreign Resident Identification Card/Passport | Address

Telephone | Email address

Details of the representative [(3)]

Full name

National Identity Card/Foreign Resident Identification Card/Passport | Address

Telephone | Email address

Information for which the right of cancellation is being exercised

Information to which the request to cancel the processing of personal data refers

Well-founded and legitimate reasons for which I request that the processing of this health information is cancelled

I HEREBY DECLARE THE FOLLOWING:

I have been informed that:

- Accessing Shared Clinic Records improves the quality of care for the general public and enables healthcare professionals to share and use all the information available on a patient between the different institutions in Catalonia;
- Exercising the right to cancel the processing of health data that appears on the Catalan Shared Clinic Records may hinder healthcare provision in other centres because they will not have access to all my health information, which may lead to risks and shortcomings in the healthcare provided.

I REQUEST THE FOLLOWING:

I wish to exercise the right to cancel the processing of the health information specified on this form, for which I attach accrediting documentation, in accordance with Article 16 of the Personal Data Protection Act 15/1999, of 13th December, and I declare that I understand and accept the consequences that this cancellation may entail.

Attached documentation

- □ Photocopy of the National Identity Card, Passport or other valid document that identifies the interested party
- □ Photocopy of the National Identity Card, Passport or other valid document that identifies the interested party's representative
- □ Photocopy of the document accrediting power of representation
- □ Documentation accrediting the well-founded and legitimate reasons for which the interested party requests the cancellation of the processing of the aforementioned health information (please specify the documentation)

Signature

Date

Preferred channel for response □ email □ letter □ in person

[4] I hereby responsibly declare that I have parental authority over my son/daughter and that there are no circumstances that restrict or limit in any way the power of representation that I am granted by this parental authority.

Date and signature

1 In accordance with the provisions of the Personal Data Protection Act 15/1999, of 13th December, you are hereby informed that your personal data will be included in an administrative file owned by the Fundació de Gestió Sanitària de l'Hospital Santa Creu i Sant Pau (FGSHSCSP), for the purpose of processing your request. This information will be received by all of the Hospital's services involved in processing your request. If you would like to receive more information or exercise your rights of Access, Rectification, Opposition or Cancellation (ARCO) stipulated in the data protection legislation, please contact the User Service Department located in the main lobby in the entrance on Carrer de Sant Quintí 89.

2 You must attach a photocopy of the National Identity Card, Passport or other valid document that identifies the interested party.

3 This section must be completed when the interested party is a minor, incapacitated or has expressly appointed a voluntary representative to exercise this right. You must attach a photocopy of the National Identity Card, Passport or other valid document that identifies the interested party's representative and the document accrediting their power of representation.

4 Please only complete this section in the case of requests from minors under parental authority.