HAUSARZTZENTRUM

Patient consent for data exchange with other service providers and for us to contact you

Last name, first name, date of birth

Dear patient,

We are fundamentally obliged to protect your data. We collect and process your data on the basis of our treatment relationship with you. In order to transfer your data in connection with your treatment to other service providers (e.g., other doctors, hospitals, laboratories) (e.g., by means of a doctor's letter) or to obtain it from other service providers, we require your explicit consent. Without this, we may not be able to provide adequate treatment and information to co-treating physicians and service providers. Otherwise, we must ask you to transfer the data to the service providers yourself or to obtain it from them. You can give us your consent below:

I hereby consent to my personal data (e.g., name, health insurance, medical history, diagnoses) relating to my treatment being passed on to all doctors/hospitals/medical care centers/laboratories providing further treatment to the extent necessary for the purposes of further treatment, other medical care, and complete documentation. In addition, my personal data may be obtained by these parties to the extent necessary.

If you only want to exchange data with **specific** doctors/hospitals/medical care centers/laboratories, please list them here:

If necessary, I would like to be reminded of check-ups and agreed or medically necessary treatment appointments, and I agree that the practice may contact me by email, text message, or telephone for this purpose.

I am aware that I can revoke all consents given to the doctor at any time without formal notice. The revocation is only valid for the future; previous data transfers remain lawful. g.

Location	**Date**	**Signature**

See the back of the form

HAUSARZTZENTRUM

[Only for existing Patients]

Patient consent

Dear patient,

This practice has been taken over by a new owner and will continue to operate at the same location.

As part of your treatment, we would like to continue using your previous treatment data for the purpose of continuing your treatment. If you object to this, the data collected by the practice to date (your patient file) may no longer be accessed from now on.

By signing this form, you voluntarily and expressly consent to the continuation and use of your collected patient file. You may revoke your consent as long as there are no legal regulations, such as retention periods, that prevent this.

If you have any questions, your doctors will continue to be available to assist you.

Location	**Date**	**Signature**

Praxis Stamp