



HAUSÄRZTE OBERKASSEL

Declaration of consent to the survey / transmission of patient data acc. § 73 (1b) SGB V



.....
Name, first name



.....
Date of birth



.....
Phone number

agree, that

my family doctor collects, stores and processes personal information concerning my person, which is not required exclusively for the treatment.

my family doctor may request treatment data and findings from other doctors and healthcare providers regarding my documentation and further treatment.

my family doctor may transmit my personal treatment data and findings to doctors and service providers for further treatment.

Should I change the family doctor, I agree that the data stored about me will be transmitted to my new family doctor, according to my information, or my new family doctor may request this data. I understand that I may revoke this statement at any time in whole or in part for the future. Data sharing covered by the consent remains legal. The consent is voluntary. The treatment ratio is not dependent on this. The complete information on the General Data Protection Regulation is available in our doctor's office.



.....
Place and date



.....
Signature of the patient or legal representative

In order to be able to offer you our service by Email, we require your consent, unless you have already given us this in the past.

- YES, I would like to be reminded of recurrent check-ups („recall“) via mail or e-mail.
- YES, I would like to receive information letter / doctor's letter via e-mail (about 3-4 times a year).



.....
Your Email address

I understand that I may revoke this consent at any time in whole or in part with effect for the future.



.....
Date



.....
Signature of the patient or legal representative