RADIOLOGISCHE PRAXISGEMEINSCHAFT

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PATIENT CONSENT

FOR THE TRANSMISSION AND COLLECTION OF DATA

Dear patient,
we may only pass on your data to third parties if this is provided for by law (e.g. for processing the treatment contract or for billing with the Association of Statutory Health Insurance Physicians) or if we have received your consent. In order to be allowed 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), your consent is required. Without your consent, we are unable to provide adequate information to subsequent treatment and service providers. You may then have to provide the necessary information yourself. You can give us your consent below:

CONSENT TO THE DISCLOSURE OF DATA

I hereby consent to,

Name: _____

Date of birth: _____

Address: _____

Phoneno: ✗ _____

agree that data about the medical treatment at the Radiologische Praxisgemeinschaft Heinsberg may be passed on to

□ my general practitioner, specialists providing further treatment, hospitals

□ and to: **please enter the names of relatives/trustworthy persons**

_____

may be passed on.

I am aware that I can informally revoke this consent to the physician at any time only with effect for the future; data transfers previously carried out and covered by this consent remain legal.
At the same time, I release the above-mentioned physicians or the physicians employed by the above-mentioned facilities from their duty of confidentiality.

Heinsberg, _____ _____
Date Signature