

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



Name, first name



Date of birth



Phone number

I 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 for the purposes of 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 carried out based on this consent remains lawful even after revocation. The consent is voluntary. The provision of treatment is not contingent upon this consent. The complete information on the General Data Protection Regulation is available in our doctor's office.



Place, date

X

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 receive reminders for recurrent check-ups („recall“) via mail or Email.
- YES, I would like to receive information letter / doctor's letter via Email (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

X

Signature of the patient or legal representative