CONSENT FORM SHARING MEDICAL DATA

**This form is only valid if it is completed in full**

Last name patient:                                                     F / M / X

Initial(s)/nickname:
Date of birth:

Address:

Postal code and city:

Phone number(s):

Signature: Date: Place:

**By signing this form, the above-mentioned patient voluntarily agrees to the provision of medical data to:**

Name: Date of birth:

Phone number:

Relationship with patient: mother / father / son / daughter / legal mentor / personal assistant

/ other\*…………………………………………………………………………….(\*please circle)

Possibly second person:

Phone number:

Relationship with patient: mother / father / son / daughter / legal mentor / personal assistant

/ other\*…………………………………………………………………………….(\*please circle)

**Please check below what you give permission for:**

* Requesting results/examinations
* Collecting letters/referrals
* Being called if my GP cannot reach me
* Requesting information from my file
* Call the practice on my behalf, for example to ask when you have an appointment or what has been agreed on medically

**Without your permission, we will only pass on medical data to you. It is possible to withdraw this permission at any time. This form will remain valid until you indicate that you no longer wish to grant permission.**