Consent for Data Transmissions Between the Medical Care Center and General Practitioners / Other Referring / Follow-up / Subsequent Treating Physicians / Third Parties

Gesundheitszentrum Recura GmbH, Neucoswiger Str. 21, 01640 Coswig

(Declaration of Consent pursuant to Art. 6 Abs. 1a, Art. 9 Abs. 2a DS-GVO)

Patient's First and Last Name (please print):

_____

Date of Birth: _____

Residence: _____

1. Data Transmissions to General Practitioners / Other Physicians / Healthcare Providers:

I hereby consent that the Medical Care Center may transmit my treatment data and medical findings to my general practitioner / other referring / follow-up / subsequent treating physicians for the purpose of documentation and/or further treatment. In particular, the transmission to my general practitioner serves the creation and completion of a centralized medical record and, if applicable, further treatment. This consent applies regardless of the method of transmission and whether my follow-up treatment is immediately assumed by my general practitioner / other physician / healthcare provider.

Multiple physicians may be specified:

_____
(Name and address of physician)

_____
(Name and address of physician)

_____
(Name and address of physician)

2. Request for Data from General Practitioners / Other Physicians / Healthcare Providers:

Ich bin damit einverstanden, dass das Medizinische Versorgungszentrum die bei meinem Hausarzt bzw. sonstigen Vorbehandlern/Behandlern vorliegenden Behandlungsdaten und Befunde, soweit diese für meine Behandlung erforderlich sind, anfordern kann. Das Medizinische Versorgungszentrum wird die Daten jeweils nur zu den Zwecken verarbeiten, zu denen sie übermittelt worden sind.

Multiple physicians may be specified:

_____
(Name and address of physician)

_____
(Name and address of physician)

Your consent is voluntary. If you do not provide consent, this may potentially result in disadvantages for your current or future treatment if relevant medical data is unavailable.

You have the right to revoke your consent in whole or in part at any time without stating reasons. In the event of revocation, no further data transmission between the aforementioned healthcare providers/other third parties will take place. The revocation must be submitted to the Medical Care Center. The revocation will only take effect from the time it is received and has no retroactive effect—any data processing prior to revocation remains lawful.

_____
Place, Date

_____ _____
Patient's Printed First and Last Name Patient's Signature

I am acting as an authorized representative / legal guardian / caregiver

_____ _____
Representative's Printed Name Representative's Signature

_____
Representative's Address

_____
Type of Representation** (legal guardianship/power of attorney/caregiving/…)