Form consent recall and for the transmission of personal data

1.) Consent to remember

Vaccinations offered by statutory health insurance

in the following way ( ) email ( ) telephone

( ) **I agree** that my doctor may remind me for the reason listed above. This declaration of consent can be revoked orally or in writing to the practice at any time.

( ) **I do not consent** to my doctor contacting me for the reasons listed above.

2.) Transmission of findings to relatives

( ) I **consent** to the transmission of findings/issuance of prescriptions and referrals to the following relatives

First name Name	Telephone number	birth date

( ) I do not consent to the transmission of findings/issuance of prescriptions and referrals to relatives **.**

3.) Transmission of prescriptions to pharmacies

( ) I consent to prescriptions being issued to the following pharmacy.

Please enter your desired pharmacy.

Pharmacy name	Address	Telephone number

( ) I do **not consent** to the release of prescriptions to pharmacies

4.) Transmission of findings to other doctors and hospitals

In principle, I agree that if there is a referral, a laboratory referral or hospital treatment as part of the necessary medical treatment, data may be exchanged between the treating doctors without my consent being required.

( ) Exceptions: In the case of the following special findings (e.g. neurological findings) or to the following doctors or to the following disciplines, **in principle no personal data and in particular no health data should be transmitted.**

Special Findings: _____

Doctors: _____

Specialties: _____

( ) No exceptions: Findings and **personal data and in particular special findings** may be transmitted to participating physicians of all disciplines without restriction

I am aware that I can revoke this declaration in whole or in part at any time for the future.

I have read and understood this notice.

Surname: _____

First name: _____

Date of birth: _____

Telephone number: _____

E-mail address: _____

_____ _____

Place, Date Signature Patient