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Patient Consent for Processing, Transmission, and Acquisition of Data

Dear Patient,

Protecting your data is important to us. Due to the treatment relationship with you, we are allowed to collect and process your data. In order to transmit your data to other service providers (e.g., other doctors, hospitals, laboratories) in connection with your treatment (e.g., via medical reports) or to obtain information from other service providers, we require your consent. Without this, we cannot adequately treat and inform other healthcare providers and service providers. Otherwise, you may need to provide the necessary information yourself. Prescriptions, orders, and similar data may only be issued directly to you. Your consent is required if they are to be issued to third parties, such as relatives or care facilities. The collector must identify themselves accordingly. Please note that the release of documents allows conclusions to be drawn about your medical condition.

Kind regards,

Your Team at Dr. Mücke's Practice

Family Name	**First Name**	**Date of Birth**

I. Provision and Treatment according to Book 5 of the Social Security Code (SGB V)

I consent to my contracted physician, as mentioned above, being able to request and transmit treatment data, findings, and prescriptions concerning me to other physicians, psychotherapists, and other medical service providers (hospitals, nursing services, etc.) for the purpose of further care, treatment, and documentation, each on a legal and contractual basis, for the duration of the treatment relationship, securely and with this purpose-bound permission.

II. Authorization of Third Parties (optional)

Furthermore, I consent to the following named third parties being allowed to receive or be provided with the listed data and prescriptions (please check applicable) by the aforementioned contracted physician, so that medical confidentiality and data protection confidentiality do not apply to:

Relatives / Life Partner / Other Authorized Parties

1. Family Name, First Name, Date of Birth ---------- ---------- (If applicable, specify relationship, e.g., Spouse, Parents, Child, Friends)	☐ Personal Data ☐ Treatment and Diagnosis Data ☐ Prescriptions and Recipes ☐ Medication Plans

2. Family Name, First Name, Date of Birth ---------- ---------- (If applicable, specify relationship, e.g., Spouse, Parents, Child, Friends)	☐ Personal Data ☐ Treatment and Diagnosis Data ☐ Prescriptions and Recipes ☐ Medication Plans

3. Family Name, First Name, Date of Birth ---------- ---------- (If applicable, specify relationship, e.g., Spouse, Parents, Child, Friends)	☐ Personal Data ☐ Treatment and Diagnosis Data ☐ Prescriptions and Recipes ☐ Medication Plans

Patient Transport / Transport Company / Shuttle Service

☐ Personal Data

I am aware that the aforementioned authorized third parties may be required to provide proof of identity if they are not personally known at the practice. Similarly, medical service providers listed under Item I, whose employees appear at the practice on my behalf (e.g., nursing home, medical supply store, home care nursing, etc.), may also be required to provide proof of identification.

III. Possibility of Revocation

I am aware that I can revoke this consent to the doctor at any time without formalities. The revocation shall only apply with effect for the future; previous data transmissions remain lawful.

Bonn, _____ _____

place, date signature