



for Publicly and Privately (Supplementary) Insured Patients

Dear Patient,

As part of your treatment at the S | Medical-Center, personal data such as your identity, social status, and medical data necessary for your care may be collected, recorded, stored, processed, retrieved, and used. In accordance with data protection regulations and within the scope of their intended use, such data may be transmitted to third parties. For more information and your rights as a data subject, please refer to the leaflet **“Information Obligations Regarding the Collection of Personal Data”**, which is available for viewing at any time in our practice.

To ensure smooth operations, we cooperate with external service providers and laboratories. Necessary data is forwarded to these companies and laboratories to the extent appro-

priate, where it is processed by them—among other things—as commissioned data processors for the purpose of delivering the agreed services. An overview of the currently contracted external service providers and the services provided can be found in the **“Information Sheet on Data Transmission”**, available in the practice. You may ask your treating physician which of your data is affected and to what extent. The data will be stored for as long as necessary for the provision of services or documentation purposes and will be deleted thereafter—where possible. Laboratories are subject to their own retention obligations.

Name, First Name

Date of Birth

I consent to the S | Medical-Center, as necessary, transmitting my patient data to external service providers for the purpose of fulfilling the assigned tasks. Furthermore, I consent to the S | Medical-Center transmitting my patient data, as necessary, to external laboratories for the purpose of analyzing medical samples.

I provide this consent voluntarily. This declaration of consent may be withdrawn at any time without stating any reasons and must be addressed to the S | Medical-Center. Please note that your withdrawal becomes effective only from the moment it is received by the S | Medical-Center. It does not have retroactive effect. The processing of your data up to that point remains lawful.

Refusal to give consent may significantly affect or potentially prevent the course of treatment.

Date:

Signature of the patient or
authorized representative:

Information and Declarations of Consent

on the Transmission and Processing of Data to and by Third Parties

Data Transmission between the Medical Center and General Practitioners / Other Referring / Follow-Up / Continuing Care Providers *(Declaration of Consent in accordance with Art. 6 Abs. 1 a, Art. 9 Abs. 2a DS-GVO)*

☐ I consent to the S | Medical-Center obtaining from

(Name and address of the doctor(s), if known)

(Name and address of the doctor(s), if known)

may **request** the available treatment data and findings, insofar as they are necessary for my treatment. I release this doctor / these doctors from their duty of medical confidentiality. The S | Medical-Center will process the data solely for the purpose for which it was transmitted.

☐ I consent to the S | Medical-Center transmitting treatment data and findings related to me to my general practitioner and/or other referring, follow-up, or continuing care providers. In particular, the transmission to the general practitioner serves to create and complete a central medical record maintained by them and, if applicable, to support further treatment. My consent applies regardless of whether my follow-up treatment is taken over immediately after my treatment at the S | Medical-Center by my general practitioner or another doctor or provider. I therefore release the treating physicians at the S | Medical-Center from their duty of medical confidentiality to this extent.

Date:

Signature of the patient or
authorized representative

I wish the **following individuals** to be allowed to receive information about me in connection with my medical treatment:

(Name, First name)

(Name, First Name)

I also consent to the S | Medical-Center using my postal address, email address, and telephone number for patient information and for the recall system (appointment reminders).

I provide this consent voluntarily. Refusal to give consent may result in disadvantages in current or future treatment if relevant medical data is not available.

This declaration of consent may be revoked at any time without stating any reasons and must be addressed to the S | Medical-Center. In the event of revocation, no further data transmission will take place between the above-mentioned healthcare providers and the S | Medical-Center. Please note that your revocation becomes effective only from the time it is received by the S | Medical-Center. It does not have retroactive effect. The processing of your data up to that point remains lawful.

Date:

Signature of the patient or
authorized representative