

# Declaration of Consent for Data Collection/Processing of Patients' Data

in accordance with the EU General Data Protection Regulation (GDPR)

ID:




I,

---



Last name, first name

hereby declare that I agree to having my patient data for **Dr. med. Udo Richter's** practice collected and processed.

An information sheet on data protection is available in the practice for viewing, about which I am also entitled to ask questions

-  about the extent and type of my personal data
-  about the legal framework for processing
-  about the possibilities of withdrawing my consent and on the consequences.

I agree to

-  allowing my patient data and diagnosis to be passed on to other doctors/psycho-therapists and health care providers for the purpose of documentation and further treatment.
-  having data regarding my diagnosis and treatment be passed on to other doctors/psycho-therapists and health care providers. This includes, for example, laboratories for determining certain test results (such as blood count), which are necessary for treatment and diagnosis.

I am aware that I can withdraw my consent at any time in part or completely in the future. I have been informed of the consequences of withdrawing my consent.

## Optional/Voluntary:

- I agree to the use of my personal data for any possible change of appointments or for appointment reminders (e.g. for health checks or vaccinations required).
- I agree to having reminders be recorded on my answering machine/my mailbox for the purpose of conveying information (e.g. change of appointment times / reporting important results).
- I agree that, for cases in which I am ill or unable to come, the **following person(s)** are authorized to come to the practice and pick up any documents for me (for example prescriptions or similar documents) or receive information on my condition (e.g. lab results or such).

If you do not agree to this, we may not provide any other person with your prescriptions or such.

---

City, date, signature of patient or legal guardian