MVZ
ORTHOPÄDIE
MÜHLENKAMP

Written consent under the General Data Protection Regulation

You wish to be treated in our practice. As a result, a treatment contract is automatically concluded. The personal data in the treatment contract, especially your name, contact details, and data concerning health, which are required and necessary solely for the purpose of implementing the resulting contractual relationship, are collected on the basis of legal authorisation.

Any additional use of personal data and the collection of additional information regularly requires the data subject's consent. You may freely give such consent in the section below.

I agree that MVZ Orthopädie Mühlenkamp may, on medical grounds, request my data from / forward my data to

☐ Further/other attending physicians ☐ Hospitals

☐ Pharmacies, medical supply ☐ Physiotherapists

stores.

☐ **I do not want my data to be passed on to other medical institutions or other third parties.**

I agree that MVZ Orthopädie Mühlenkamp may then receive/send my data from/to the aforementioned partners via/by

☐ FAX ☐ Post

Name:	**Adress:**
Doctor:	
Referring Doctor:	
Other Doctor:	

Please See overleaf!

ORTHOPÄDIE

UNFALLCHIRURGIE

SPEZIELLE ORTHOPÄDISCHE CHIRURGIE

SPEZIELLE UNFALLCHIRURGIE

RHEUMATOLOGIE

SPORTMEDIZIN

Mühlenkamp 33a
22303 Hamburg
Tel. 040/27 83 99 0
Fax 040/27 83 99 50
orthopaedie-muehlenkamp
@helios-gesundheit.de
www.mvz-om.de

OPERATIVE ABTEILUNG

Orthopädische Chirurgie Hamburg

Helios ENDO-Klinik Hamburg

Holstenstraße 2
22767 Hamburg

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In the event that I make a personal request for documents, prescriptions, etc., I agree that my documents may be sent to me by

☐ Post ☐ Email **(not for communicating findings)**

I agree that appointment reminders may be sent to me as text messages

☐ YES ☐ NO

The following person(s) may also collect/receive the aforementioned documents for me. Please state name in block capitals:

_____

_____

_____

_____

I am aware that I may withdraw this consent, or parts thereof, at any time in the future, without giving any reason.

Place, Date _____

_____
Signature of the patient or parent

_____
Legal representatives

_____
Translator / Witness

_____
First Name – Family Name

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