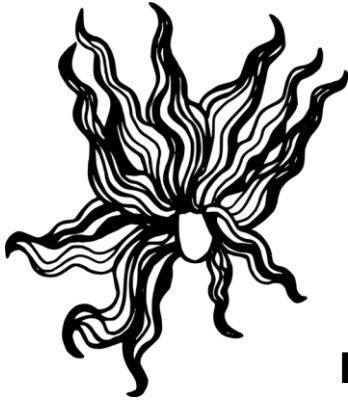




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Patient Consent & Confidentiality Waiver

Dear Patient,

Please check the boxes below to indicate which data processing activities you consent to. Providing consent is **voluntary** and does not affect your medical treatment.

1. Laboratory Testing & Direct Billing by the Laboratory

I consent to the practice forwarding my samples (e.g., swabs, blood samples) and the required personal data (name, date of birth, address, provisional diagnosis) to the medical laboratory for analysis. The laboratory will bill me (private liquidation) or my health insurance directly for its services. For this purpose, I release both the practice and the laboratory from their medical confidentiality obligations.

☐ Yes, I consent. | ☐ No.

2. Results via Unencrypted Email / SMS

I consent to the practice sending me medical results or appointments unencrypted. I am aware that unencrypted digital data transmission involves potential security risks on the internet.

Email: _____ Mobile No.: _____

☐ Yes, I consent. | ☐ No.

3. Data Exchange with Colleagues & Laboratories

I consent to the practice sharing my medical data (e.g., medical reports, lab results) with and requesting it from other physicians, therapists, or laboratories involved in my ongoing treatment.

☐ Yes, I consent. | ☐ No.

Right of Revocation: You have the right to revoke this consent at any time without giving reasons (e.g., via email or verbally) with future effect.

Place, Date

Patient Name (in block letters)

Signature of Patient / Representative