



Declaration of consent to collect/ transmission patient data

I,

Family Name, Name, Date of Birth

agree, that my patient data will be collected and processed at Practice Dres. med. von Blittersdorff. An information sheet on data protection is available for inspection in practice and can be handed out to me at any time.

I agree that

treatment data and findings concerning me, e.g. medical reports, can be requested from other doctors / psychotherapists and service providers for the purpose of documentation and further treatment.

treatment data and findings concerning me may be passed on to other doctors / psychotherapists and serviceproviders treating me, e.g. doctor's letters. This includes, for example, labworks that are used to create certain test results (such as blood test results) that are required for treatment and diagnosis.

I am aware that the declaration can be revoked in whole or in part for the future at any time.

- I consent to use of my data for certain other purposes beyond the treatments.
In particular, I agree to practice mailings, information and appointment reminders beyond the treatment case.
- I agree to get information by telephone
- I agree to information and correspondence by e-mail
My e-mail address is

I prefer to receive my checks via e-mail via letter.

The Following people may receive information about me (e.g. spouse, parents, kids) :

Heidelberg, the

Signature of Patient or legal representative