Name of patient:	*Patient label*

"***Consent to disclosure of treatment information***

Dear patient,

due to privacy protection regulations (Art. 9 DS-GVO, § 22 BDSG in the version valid starting on May 25, 2018 in conjunction with § 73 Para. 1b SGB V) we may disclose treatment data and findings concerning your person only to other physicians for the purposes of your (further) treatment if you specifically ask us to do so or consent to the disclosure.
During treatment it often happens that other medical instances involved in the treatment (specialists, hospitals, Medical Service of the Health Funds (MDK)) require treatment data and findings from us for your further medical treatment. For this purpose, upon request we can provide you with copies of your treatment data and findings at any time to submit to the other instances involved in your treatment. In order to simplify the process, we could also send the corresponding treatment data and findings directly to your other physicians involved in your treatment without you having to do anything else. For this we need your written consent. Only with this consent can we transfer your treatment data and findings to the other medical instances involved in your treatment.
For this purpose, we ask you to check the box next to the statement that corresponds to your wishes and to sign this form on the bottom.

☐ *I agree that the transmitting physician receives my treatment data / findings without my expressly written instruction. I declare that the transmitting physician is authorized to acquire my treatment data and findings at the Radiology Center Hoheluft and to process it for my further treatment.*

(In addition to this statement, you may also check the second point)

☐ *I agree that other physicians involved in my treatment may receive my treatment data / findings upon request, if their request demonstrates to Radiology Hoheluft that I have consented to the acquisition of my treatment data / findings from Radiology Hoheluft and processing as part of my further treatment by the physicians involved in my treatment.*

You can withdraw this consent at any time effective for the future. (City, date, and signature)"

....., date ....

(City) (Date) (Signature patient)