Submission of medical documents

Declaration of consent

Last Name:
First name:
Date of birth:
Address:
Telephone number:
Previous doctor:
E-mail address (required for option 1):

I release Arcus Praxiszentrum AG from the obligation to retain my medical records.

o I would like to receive the documents by e-mail to my e-mail address. (Your e-mail is not protected, for more information please refer to our data protection information)

o I will collect the files for my future doctor in person at the practice. (USB stick, must be clarified with the future practice whether this is accepted)

- My files will be collected for me from _____.
(Name, relationship to the patient, telephone number)

o I would like the files to be sent to my future doctor by e-mail. (HIN-protected e-mail address required).

- Name of the practice and the treating doctor

_____
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With my signature I confirm that I have received all the necessary information and that I agree to them.
I authorize the disclosure of my files in accordance with my consent.

Date, place:
Signature: