Declaration of data protection

Dear patient,

You are agreeing to the treatment contract for the ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice of endocrinology. There will be a doctor responsible for you at the location of your choice.
The ‚Zentrum für Endokrinologie und Stoffwechsel' is a local joined practice for endocrinology and is represented at the following locations, with the following doctors:
**Our locations:** Regensburg, München, Landshut, Ingolstadt
**Our doctors:** Prof. Dr. med. Christian Seifarth – Prof. Dr. med. Harald Schneider– Priv.-Doz. Dr. med. George Vlotides and colleagues.

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A part of the treatment of ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology is the requisition and evaluation of external findings. The further transmission of internal and external findings to the family doctor and specialists for the evaluation/treatment of your illness is often necessary.
Following §73 - 1b SGB V the written approval of our patients is necessary. For this reason, we ask you to sign our declaration of confidentiality release.

**Hereby I, (please write down your name and date of birth)** – PLEASE WRITE IN BLOCK LETTERS

Name/forename: ______________________________ Date of birth: ____________________

Current phone number: ______________________________ (preferably mobile phone)

Your email-address: ______________________________

- allow my supervising doctor to transmit medical findings to the 'Zentrum für Endokrinologie und Stoffwechsel',
- allow the doctors of ‚Zentrum für Endokrinologie und Stoffwechsel' to transmit findings to my supervising doctor,
- I agree that medical findings, which are relevant for my evaluation/treatment are ordered in written form, by phone or via fax.
- I also agree that findings are transmitted to other doctors, if it is necessary for the evaluation of the illness and the treatment.
- I am okay with my treatment reports being transmitted to the doctors I named below.

- With my signature I agree to my doctors exchanging information about the history of the disease, findings, therapy and further treatment.

Please name your doctor/family doctor **with the address of the practice** – PLEASE WRITE IN BLOCK LETTERS

Name/first name: ______________________________ Location/city: ______________________________

Name/first name: ______________________________ Location/city: ______________________________

We send your findings to other doctors by mail or fax. If you wish to get a copy of your findings, you have to get it from our practice personally or we will send it to you by eService. **Documents can not be sent to our patients by mail or fax.** You can use our coded service called CGM eService. This service is free.

O I came **WITH a** valid referral letter for todays appointment and agree with my signature, that the doctor named above is allowed to receive detailed findings by mail or by fax. (please mark with a cross if applicable)

O I came **WITHOUT** a valid referral letter for todays appointment and agree with my signature, that the doctor named above is allowed to receive detailed findings by mail or by fax. (please mark with a cross if applicable)

O I **decline** the transmission of my data to other practices and don't agree with the points stated above. I want my findings to only be transmitted to myself or to be handed over to myself. I'm registered at the eService and pay the expenses by myself when I pick up my documents.
(please mark with a cross if applicable)

**Delivery of receipts and referral letters**

We gladly send receipts or referral letters to our patients. However, you need to pay the expences by yourself. If you didn't leave 1€ for material and postage costs behind, we can not send them to you. You need to get the wanted documents personally at our practice.

O I don't want to leave material and postage costs in the amount of 1 Euro behind and collect my receipts/referral letters personally.

O I paid 1 Euro and want receipts/referral letters to be sent to me.

Please turn around!

Seite 2

## Power of attorney

Hereby I give authority to the person/s named below. The authorized person is allowed to get informed about my history of illness or and treatment by the responsible doctor of ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice of endocrinology. The authorized person is also allowed, to be informed about findings by phone or in person. The power of attorney is also valid for picking up receipts, referral letters and other documents, which are valid for the treatment.
The power of attorney can be revoked by me at any time and is only valid if the authorized person can provide identification with their identity card. The collection of documents without valid proof is not possible.

(Please write down the full name and date of birth of the person) – PLEASE WRITE IN BLOCK LETTERS

O Surname/first name: ____________________________________________ Date of birth: ___________________________

O Surname/first name: ____________________________________________ Date of birth: ___________________________

## Providing information by phone

I agree, that the ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology can contact me anytime by phone or e-mail. I informed the ‚Zentrum für Endokrinologie und Stoffwechsel' about my current phone number and e-mail address, that can't be accessed by third parties. Should a third person get access to my phone and get informations about my findings because of my own carelessness, it is my own fault. The ‚Zentrums für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology isn't liable for such cases. All juristic and legal consequences are carried by myself.

## Appointment reminder

O Yes, in the future I want to be reminded of my next appointment by the 'Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice of endocrinology
O by SMS O by E-Mail (Laboratory- and phone appointments excluded)

O I don't want to be remembered of my appointments by ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology.
I arrange my appointments by myself.

## Accuracy of your statements

**Important information for our patients:** We renew our contract yearly. If any of your informations changed in the meantime, please contact us immediately, since you are responsible for the accuracy of your statements as a patient.

I filled in the formular precisely and have been informed, that if my informations changes in the meantime, I need to contact the ‚Zentrum für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology immediately. If I fail to do so, it is my own responsibility and not the fault of the 'Zentrums für Endokrinologie und Stoffwechsel'/Local joined practice for endocrinology. All juristic and legal consequences are carried by myself. I know that I can the revoke my statements at anytime with regard to future arrangements.

Munich, the __________________ Signature ____________________________________________________
(Signature of the patient or legal guardian)

I know that this is voluntary information and that it can be declined anytime in the future.
Please also take a look at our posting about **data protection** in the waiting room.