

UROLOGIE BERLIN-ADLERSHOF

Consent for the Processing of Personal Patient Data according to Art. 6, 7 para. 1 lit. a GDPR

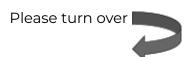
Surnai	me/Name	Bday:	
Street	/No:		
Postco	ode/city:		
Email:		Phone:	
To ens	ent to Contact by the Pract sure we can reach you during to reply to your emails or in to schedule appointments or to share your test results to tick the boxes to indicate in email (Unencrypted)	your treatment, we may need to cont nquiries, or send reminders, 5.	eact you – for example: Post
Some persor		Results for your further treatment, for example ect the reports in person at our practic	=
0	Unencrypted email (free, voluntary service): I agree to receive findings as unencrypted PDF files via email. I have been informed that unencrypted emails carry a certain risk of unauthorized access by third parties. I knowingly accept this risk and waive encrypted transmission. The dispatch will occur only if medically necessary.		
0	Encrypted email (subject to charge): I request the delivery of my findings via encrypted email. This service is subject to a fee according to the German Medical Fee Schedule (GOÄ): GOÄ code 2; factor 3.5 = EUR 8.15 incl. VAT.		

Consent to Sharing and Exchange of Medical Data

I consent to the forwarding of my samples (e.g., blood, tissue, urine, stool) to contracted laboratories for diagnostic purposes. Findings may also be shared with my treating physicians (e.g., general practitioner). Urologie Berlin-Adlershof may request relevant medical information from other doctors and use it for my treatment.

Revocation and Data Processing Notice: I understand that I can revoke this consent in writing at any time (Art. 7 para. 3 GDPR). The revocation applies only to the future; the legality of the data processing carried out up to that point remains unaffected. I acknowledge that Urologie Berlin-Adlershof uses appropriate technical safeguards to protect patient data, including encrypted communication channels. The full privacy policy can be found at: https://urologie-berlin-adlershof.de







Please tick where applicable:

General: Height (cm): Weight (kg): Pregnant / Breastfeeding \square Previous urologists:
Urological history: \square Urinary tract infections - \square Kidney stones - \square Problems with urination - \square Erectile dysfunction - \square Blood in urine - Other:
Cancer history:
Lung conditions: ☐ Asthma - ☐ Chronic bronchitis - ☐ Tuberculosis Other:
Metabolic / endocrine conditions: □ Diabetes - □ Hyperthyroidism -□ Hypothyroidism -□ Liver disease -□ Kidney disease - Other:
Nervous system conditions: ☐ Seizure disorder - ☐ Depression -☐ Parkinson's disease - ☐ Multiple sclerosis - Other:
Use of psychoactive substances: \square Alcohol - \square Nicotine - \square Cannabis -Other:
Heart / circulatory system: □ Coronary heart disease - □ Heart failure -□ Heart rhythm disorders - □ Pacemaker -□ High blood pressure -□ Low blood pressure -Other:
$Blood\text{-related conditions:} \ \square$ Bleeding tendency - \square Blood-thinning medication
Infectious diseases: ☐ HIV - ☐ Hepatitis - Other:
Which allergies do you have?
Which medications are you currently taking?
Which operations have you had, and when?

I confirm that the above information is accurate to the best of my knowledge. I will inform the treating physician of any changes.



Date/Signature: