UROLOGIE BERLIN-ADLERSHOF

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

Surname/Name Bday:

Street/No:

Postcode/city:

Email: Phone:

Consent to Contact by the Practice

To ensure we can reach you during your treatment, we may need to contact you – for example:

- to reply to your emails or inquiries,
- to schedule appointments or send reminders,
- or to share your test results.

Please tick the boxes to indicate how we may contact you:

◯ email (Unencrypted) ◯ Telephone ◯ Post (postage appears)

Consent to Receive Medical Results

Some medical reports are needed for your further treatment, for example by other doctors. You (or a person authorized by you) can collect the reports in person at our practice, or you can choose one of the following options:

◯ **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.

◯ **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

X Date / Signature:

Please turn over

Anamnesis

Please tick where applicable:

General: Height (cm): _____ Weight (kg): _____ Pregnant / Breastfeeding ☐
Previous urologists:

Urological history: ☐ Urinary tract infections - ☐ Kidney stones - ☐ Problems with urination - ☐ Erectile dysfunction - ☐ 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: ☐ Alcohol - ☐ Nicotine -☐ Cannabis -Other:

Heart / circulatory system: ☐ Coronary heart disease - ☐ Heart failure -☐ Heart rhythm disorders - ☐ Pacemaker -☐ High blood pressure -☐ Low blood pressure -Other:

Blood-related conditions: ☐ Bleeding tendency -☐ 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.

X Date/Signature: