CONSENT FORM

This form is only valid if it is completed filled in

Last name: V / M / X

Initial(s)/nickname:

Date of birth:

Address:

Phone number(s):

Signature: date: Place:

By signing this form, the aforementioned patient voluntarily agrees to provide the medical information to:

Name: Geboortedatum:

Relatie:

Eventueel 2e persoon:

Naam: Date of birth:

Relationship with patient:

Please tick below what you consent to:

- Requesting results
- Collection of letters/references
- Consult with a care provider if the GP cannot reach me
- Requesting information from my file
- Calling the practice on my behalf, for example asking when you have an appointment or what policy has been agreed

We only provide medical data without your permission through to yourself

It is possible to revoke this consent at any time. This form remains valid until I indicate that I no longer wish to grant permission